

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Page 3 should be left within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 87 23272	
1 - FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST				8:16 387 843 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 3 DAY 23 YEAR 23		6. AGE IN YEARS LAST BIRTHDAY 64		7. UNDERS 1 YEAR MONTHS 0 DAYS 0		8. HOURS HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City		10a. USUAL OCCUPATION Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 317 S. Calhoun St. 21223		12a. USUAL ADDRESS Baltimore City, MD 21207		12b. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr	
13. FATHER'S NAME FIRST Sydney MIDDLE J. LAST Hackett		13c. CITY OR TOWN Baltimore		15. MOTHER'S MAIDEN NAME FIRST Anna MIDDLE J. LAST Torture		17. INFORMANT Peggy L. Mongomery		18. ADDRESS 3433 Rollingview Ct.		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF NO OR UNKNOWN) No		16. SOCIAL SECURITY NO. 579-48-9969		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Spontaneous abortion		19. DUE TO, OR AS A CONSEQUENCE OF (b) Essential heart disease		20. DUE TO, OR AS A CONSEQUENCE OF (c)			
21a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 21) Cardiac arrest, sudden exophthalmos, stroke & hemiparesis			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f.							
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE James Evans MD		22c. DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 8/17/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James Evans MD		22e. ADDRESS 700 Washington Blvd, Baltimore, MD 21220									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/20/1987		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS The Evergreen Cemetery Baltimore, MD 21223		23d. LOCATION CITY OR TOWN Bethesda, Howard Co., Md.		23e. COUNTY Howard Co.		23f. STATE Md.	
24. FUNERAL DIRECTOR NAME JOHN J. Cowan & Son Inc.		24b. ADDRESS 901 Hawkins St.		24c. DATE REC'D. BY REGISTRAR AUG 25 1987		24d. ARRESTED NAME Julia Gordon-Lindner		24e. SIGNATURE			

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063773 AUG 26 1987

1800 AM ETTESAC

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or embalming.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other trauma, inform the medical examiner and the medical examiner will be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 23273		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
CATHERINE			M.		UDES	August 2, 1987						10:30 AM
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH August 6, 1912nd		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE			MD.			
10. CITY OR TOWN OF DEATH CATONSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RIDGEWAY MANOR NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY HOME					
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN ANNE ARUNDEL LINTHICUM		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 513 HEATH AVE			21090
14. FATHER'S NAME FIRST CASPER STENGEL		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST ELIZABETH MCCOY			MIDDLE	LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. INFORMANT MARY C. HOLTHAUS			PASADENA		ADDRESS 711 HOLLY AVE.	MD	21122	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8/1/87		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)		18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE										
		18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE										
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b)		18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b) ARTERIOSCLEROSIS CARDIO VASCULAR DIS. 1980										
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)		18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) GENERALIZED ARTERIOSCLEROSIS										
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN			COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from DEC - , 19 82 , to 8/2 , 19 87 , that (I) (we) last saw the deceased alive on 8/1 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <i>Norman R Kleiman</i>		22c. DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 8/3/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR NORMAN KLEIMAN		22e. ADDRESS 3803 EDMONDSON AVENUE, BALTIMORE, MD.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG 4, 1987		23c. NAME OF CEMETERY OR CREMATORIUM LORRAINE PARK CEMETERY		23d. LOCATION CITY OR TOWN WOODLAWN						
24. FUNERAL DIRECTOR RUSSELL C. WITZKE FUNERAL HOMES P.A.		25a. ADDRESS 1630 EDMONDSON AVE., CATONSVILLE, MD. 21228		25b. DATE REC'D. BY REGISTRAR AUG 04 1987					25b. REGISTRAR'S SIGNATURE <i>Julia Gordon Radke</i>			

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(1000)

RECORDED
BY TELETYPE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be

signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: Attest this certificate has been signed by the attending physician and is to be filed in the funeral director's office. This certificate is to be filed with the Bureau of Mortuary Practice. Then please remove carbon paper. Page 1, original to be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical certifying physician must initial the word "traumatic" in Item 21.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23274			
												REG. NO.			
1 - STATE REGISTRAR			2a. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2b. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			<i>Merrill D. Uhlfelder</i>						8/4/87			4:10 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
MALE		WHITE		JAN 17 1920			67			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			10. CITY OR TOWN OF DEATH Baltimore City					
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) N. CHARLES GEN. HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN			12b. KIND OF BUSINESS OR INDUSTRY WHOLESALE								
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6111 BERKELEY AVE. #21209						
14. FATHER'S NAME FIRST DAVID		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST ROSA			MIDDLE	LAST	16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. 219-03-3613	17. INFORMANT MRS. BLANCHE F. UHLFELDER	17c. ADDRESS 6111 BERKELEY AVE. BALTO., MD 21209
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiogenic shock</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>acute myocardial infarction</i>															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Diabetes Mellitus</i>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) saw the deceased alive on 8/4/87, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.			21d. LOCATION STREET CITY OR TOWN COUNTY STATE							
21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)													
22a. I certify that (I) (this hospital) attended the deceased from 7/18/87 to 8/4/87, that (we) lost saw the deceased alive on 8/4/87, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.												22b. DATE SIGNED <i>August 4, 1987</i>			
22b. SIGNATURE <i>Levinsky, B. Galicia, M.D.</i>		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Marcos B. Galicia, M.D.</i>		22e. ADDRESS <i>North Charles General Hospital</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG. 5, 1987		23c. NAME OF CEMETERY OR CREMATORIAL BALTIMORE HEBREW			23d. LOCATION CITY OR TOWN REISTERSTOWN		23e. COUNTY BALTO.		23f. STATE MD				
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC.		ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215			25a. DATE REC'D. BY REGISTRAR 08/12/87			25b. REGISTRAR'S SIGNATURE							

18-342 50001

23275

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

063726 AUG 26 1987

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
KATHRYN DORIS UNITAS						AUG. 23, 1987				9:48A M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		White		MONTH	DAY	YEAR	72	YEARS	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.		
Union Bridge, Md. -U.S.A.				Feb. 24, 1915				BALTIMORE CITY				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
BALTIMORE		JOHNS HOPKINS HOSPITAL				Housewife-Homemaker		21228 1008 S. Hilton Avenue				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE						
Md. Baltimore		Catonsville				21228 1008 S. Hilton Avenue						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
George		---	---	Drabic	Tilly Anna Seedor							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No		216-10-881		Mr. Edward J. Unitas, Jr.		24 Larbo Road; Millersville, Md. 21108		24 hr				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPGENIC SHOCK 24 HR.												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MYOCARDIAL INFARCTION 24 HR.												
DUE TO, OR AS A CONSEQUENCE OF (c) MITRAL VALVE DISEASE (STENOSIS) MANY YEARS												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a SEVERE PERIPHERAL VASCULAR DISEASE WITH LOWER EXTREMITY ISCHEMIA												
19a. DATE OF OPERATION 8/22/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED MYOCARDIAL INFARCTION LOWER EXTREMITY ISCHEMIA				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (we) attended the deceased from 8/16/87, 19 87, to 8/23, 19 87, that (I) (we) last saw the deceased alive on 8/23, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												
22b. SIGNATURE David L. Johnson MD		DEGREE				22c. DATE SIGNED 8/23/87						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID L. JOHNSON		ATTENDING MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/26/87		23c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer Cem.		23d. LOCATION CITY OR TOWN Baltimore, Maryland						
24. FUNERAL DIRECTOR NAME Sterling Funeral Estate, P. A. ADDRESS 736 Edmondson Avenue; Catonsville, Md. 21228		25a. DATE REC'D. BY REGISTRAR AUG 24 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Readels								

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

23276
REG. NO.

065171 SEP 10 1987

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD PENDING IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1- STATE REGISTRAR UNKNOWN #87-52		FIRST	MIDDLE	LAST	2a DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR	2b HOUR	
					OF ESTI. DEATH MATED <input checked="" type="checkbox"/> 5/25/1987	5/25/1987	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c DATE PRONOUNCED DEAD MONTH DAY YEAR	2d HOUR
M	B					5/25/1987	6:10 AM
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Unknown		Unknown				Baltimore City, MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Baltimore		6 S. Calvert St. - Rear				12b KIND OF BUSINESS OR INDUSTRY	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS
Unknown							Unknown 99999
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
Unknown						Unknown	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS	
(If Yes, give war or dates)		Unknown		B.P.D. - Central District			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hanging APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. } (b) Due to, or as a consequence of }							
(c) Due to, or as a consequence of }							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 19.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY HOUR XX MONTH DAY YEAR ? P.M. 5/24/1987		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject hanged self			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) fire escape		21f. LOCATION STREET 6 S. Calvert St., Balto. City, Md.		CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Dennis F. Smyth, M.D. ASSISTANT MEDICAL EXAMINER DATE SIGNED 5/25/87							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS				111 Penn St.	
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Removal 9-3-87		23c. NAME OF CEMETERY OR CREMATORIAL RECORD BY REGISTRAR		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME		ADDRESS		SEP 9 1987		REGISTRAR'S SIGNATURE Julia Sanders-Randall	
State Anatomy Board		Balto., Md.					

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RECORDED



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FOR
STATE
REGISTRAR

37 23277

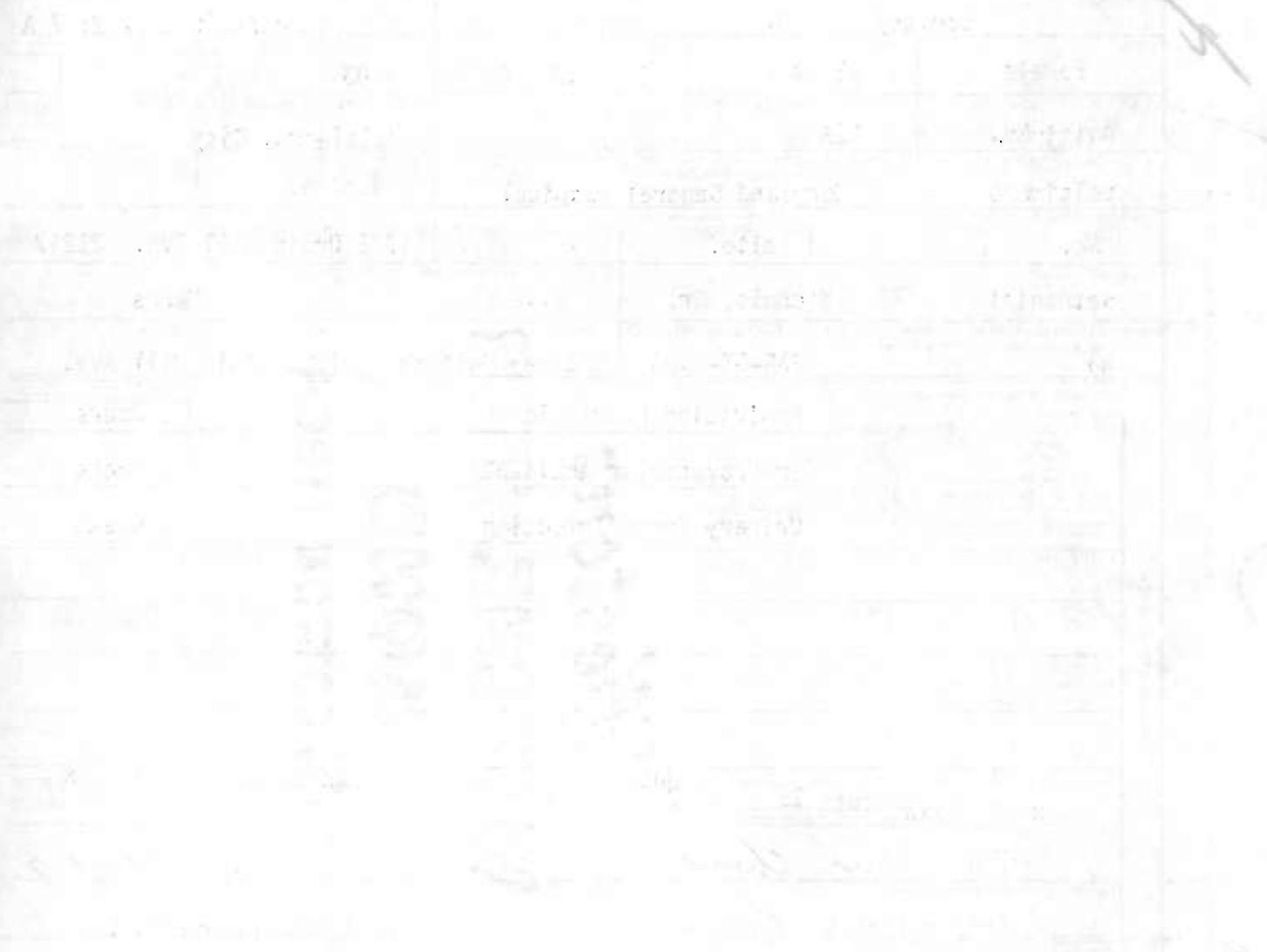
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Dorothy N. Unthank						August 15 1987				2:47 AM	
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN.		
Female	Black	MONTH	DAY	YEAR	83						
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Md.	USA				Baltimore, City MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore	Maryland General Hospital			Retired							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STREET ADDRESS / ZIP CODE					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	Balto.			1921 Druid Hill Ave. 21217					
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME					
Nathaniel					Nichols, Sr.	Ella	Middle	Manns			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			238-58-2906			Bronwen Unthank			1921 Druid Hill Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Aspiration Pneumonia						3 Hours					
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular Accident						2 Weeks					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF (c) Urinary Tract Infection						2 Weeks					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED <small>WHILE WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></small>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 28, 19 87, to August 15, 19 87, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <input checked="" type="checkbox"/> August 15, 19 87, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Dtch - Jane Chen</i>		22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED 8/15/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>LIAH LIAN CHEN</i>		22e. ADDRESS			C/O Maryland General Hospital						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/18/87		23c. NAME OF CEMETERY OR CREMATORIAL Evergreen Cem			23d. LOCATION CITY OR TOWN Winston-Salem, N.C.		STATE		
24. FUNERAL DIRECTOR NAME Wm C March F/H West		ADDRESS 4300 Wabash Ave			25a. DATE REC'D. BY REGISTRAR AUG 17 1987			25b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Lundeen</i>			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

REG. NO.

063616 AUG 25 87

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGE 4 TO FUNERAL DIRECTOR; PAGE 3 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FUNERAL DIRECTOR'S COPY OF THIS CERTIFICATE. PAGE 2 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGE 1 SHOULD BE RETAINED BY THE FUNERAL DIRECTOR FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI. DEATH MATED	MONTH	DAY	YEAR	2b. HOUR		
Harry		Charles	Updegraff		<input checked="" type="checkbox"/> 8/ 11/ 1987				M		
3. SEX	4. RACE	S. DATE OF BIRTH MONTH DAY YEAR	6 21 23	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR. MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN.	2c. DATE PRONOUNCED DEAD		
M	W			65					MONTH DAY YEAR		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH		
MD.		U.S.A.							Baltimore City,		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore		324 N. Eutaw St.							21201		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
MD.				BALTIMORE				324 N. Eutaw St. 2nd Fl.			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO.		17. INFORMANT Officer Kim Brown - B.P.D. Central District		ADDRESS					
		216-12-0694									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:		Alcoholism and Arteriosclerotic Cardiovascular Disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause lost</u> .		DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? HEAD ONLY <input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above. Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> TITLE (SPECIFY) ACTUAL SIGNATURE Dennis F. Smyth, M.D.											
EXAMINER'S NAME (TYPE OR PRINT)		Dennis F. Smyth M.D.		ADDRESS		111 Penn St.		DATE SIGNED		8/13/87	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Removal		8-19-87									
24. FUNERAL DIRECTOR NAME		ADDRESS								25b. REGISTRAR'S SIGNATURE	
State Anatomy Board		Balto., Md.								AUG 24 1987 Julie L. Wilson	

063618 May 25 2011

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be paged at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 23279			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Violet			F.		Upton	8			6	87	9 ⁴⁵ A	M	
3. SEX			F	4. RACE	W	5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	
						Dec. 19, 1903						IF UNDER 1 YEAR	
7a. BIRTHPLACE (COUNTRY)			Illinois	7b. CITIZEN OF WHAT COUNTRY?			USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
10. CITY OR TOWN OF DEATH			Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			Deatons Hosp. & Med. Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY	13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1101 St. Paul St. 21202			
14. FATHER'S NAME FIRST			Unk	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST	Logan		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			217 05 6845D	17. INFORMANT			ADDRESS		
								Mr. Roy M. Upton			101 E. 32nd St.	21218	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiorespiratory arrest</i> APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF <i>5 minutes</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Respiratory failure</i> 5 days (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>IDDM (Undated)</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from 7/21 19 87 to 8/6 19 87 that (I/we) lost saw the deceased alive on 8/6 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.													
22b. SIGNATURE <i>Eva S. Hersh MD</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 8/6/87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Eva S. Hersh MD</i>			22e. ADDRESS <i>DEATON Hospital</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/10/87			23c. NAME OF CEMETERY OR CREMATORIAL Christ Church Cemetery			23d. LOCATION CITY OR TOWN Saluda, VA COUNTY STATE				
24. FUNERAL DIRECTOR NAME MITCHELL-WIEDEFELD HOME, INC.			ADDRESS 6500 York Rd.			25a. DATE REC'D. BY REGISTRAR AUG 10 1987			25b. REGISTRAR'S SIGNATURE <i>John S. Hersh</i>				

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1. *U.S. Fish and Wildlife Service*, Biological Report, Vol. 1, No. 1, 1970.

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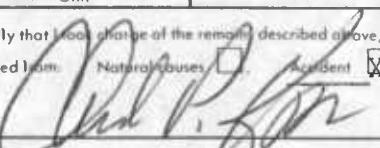
Page 10

063918 AUG 12 1987 FOR
REGISTRATION

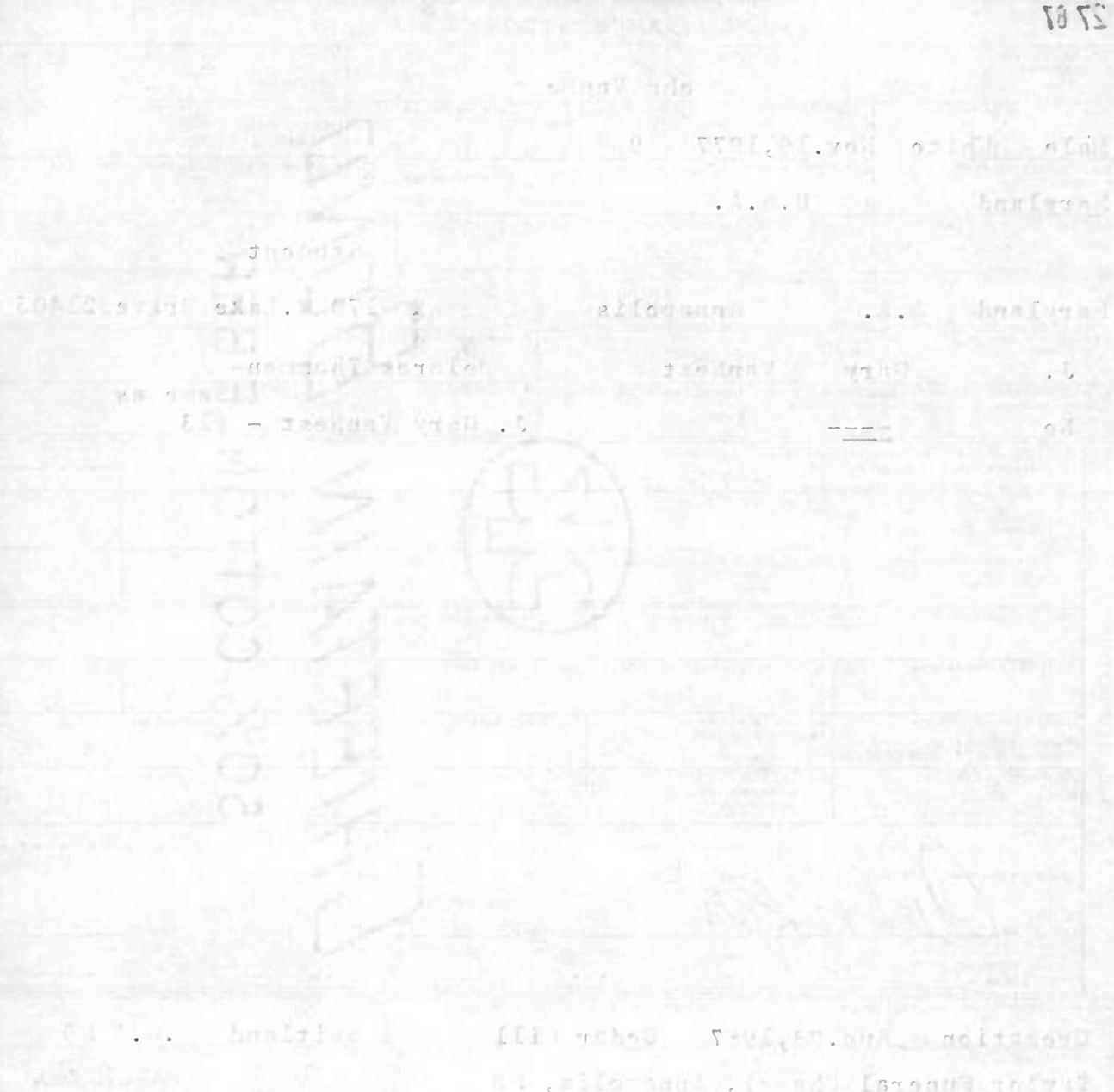
**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR	
Jesse John VanNest						<input checked="" type="checkbox"/>				8-21 1987	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d HOUR 9:30 AM	
Male	White	Nov. 19, 1977	9 yrs.			8-21					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED WIDOWED	NEVER MARRIED DIVORCED	9 BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		U.S.A.					Baltimore City				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		University Hospital			Student						
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						MD					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS					
Maryland	A.A.	Annapolis				170 W. Lake Drive 21403					
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
J. Gary VanNest			Delores Thommen								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <input type="checkbox"/> No			16b. SOCIAL SECURITY NO. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			17. INFORMANT ADDRESS			Same as J. Gary VanNest - #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Head injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
					<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) operator of bicycle struck by motor vehicle						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street			21f. LOCATION STREET East Lake & West Lake Dr., Annapolis, Anne Arundel Co., MD						
22a. I certify that <input type="checkbox"/> charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and <input type="checkbox"/> Undetermined manner <input type="checkbox"/> death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE 											DATE SIGNED
EXAMINER'S NAME (TYPE OR PRINT)											8-22-87
Charles P. Kokes, M.D. ADDRESS 111 Penn St., Baltimore, MD 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE
Cremation		Aug. 23, 1987		Cedar Hill			Suitland		P.G.		MD
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Taylor Funeral Chapel, Annapolis, MD				AUG 26 1987							

10/22/81 8:18:30



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 may be detached for use as the burial-transit permit. This page should be carbonized with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, disease, or condition which may be traumatic event, the medical examiner may be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										23281							
1 - STATE REGISTRAR			REG. NO.														
1. DEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2d. DATE OF DEATH		MONTH	DAY	YEAR	2d. HOUR				
NORMA		EVA		VATENOS				AUGUST 5, 1987					12:55 P.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH Dec. 2, 1932		6. AGE (IN YEARS LAST BIRTHDAY) 54		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS MONTHS		IF UNDER 24 HRS HOURS MIN.					
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.											
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home											
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Rosedale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8703 Deleage Rd. 21237									
14. FATHER'S NAME FIRST Andrew		MIDDLE Pappas		15. MOTHER'S MAIDEN NAME FIRST Irene		MIDDLE		LAST		Mauromatic							
16a. WAS DEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 236-62-8142		17. INFORMANT Michael J. Vatenos - same as #13e		ADDRESS											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Collapse												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fungal Sepsis												1 month					
DUE TO, OR AS A CONSEQUENCE OF (c) Leukemia (AML)												7 months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from June 16, 1987 , to August 5, 1987 , that (I) (we) last saw the deceased alive on August 5, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.																	
22b. SIGNATURE David Gerard		22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		DATE SIGNED August 5, 1987							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) David Gerard		22f. ADDRESS 600 N. Wolfe St, Baltimore MD 21205															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-8-87		23c. NAME OF CEMETERY OR CREMATORIAL Greek Orthodox Cem.		23d. LOCATION CITY OR TOWN Balto.		COUNTY		STATE Md.							
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc., Towson, Md. 21204		ADDRESS 1050 York Rd.		25a. DATE REC'D. BY REGISTRAR AUG 10 1987		25b. REGISTRAR'S SIGNATURE John J. Gerard											
DHMH - 16 60M 7/B4 (VRA 15, 4)																	

062284 AVE 11 AS

(cont'd) -

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician or by the hospital in which the deceased was confined.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon paper. Please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 23282						
1 - STATE REGISTRAR 287													REG. NO. 23282			
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR A						
RAFAEL	A.		VELAZQUEZ	AUGUST 10TH, 1987						3:35M						
1. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 21, 1946	6. AGE (IN YEARS LAST BIRTHDAY) 40			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Cuba	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY			10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Proprietor			11. KIND OF BUSINESS OR INDUSTRY Hairdressing							
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE MD	13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 835 Hollins St., 21201										
14. FATHER'S NAME FIRST Rafael	MIDDLE B.	LAST Velazquez	15. MOTHER'S MAIDEN NAME FIRST Lillia			MIDDLE	LAST	Ballenilla								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Army 261 74 2940	17. INFORMANT Bruce A. Chase	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory arrest</i>			ADDRESS Same			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) <i>Brain stem mass</i>						2 min							
			(c) <i>Acquired Immune Reflux</i>						4 yrs							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 6-17 to 8-10 , 19 87 , to 8-10 , 19 87 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on 8-10 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (they) did not view the body after death.																
22b. SIGNATURE <i>Stephen J. Noga</i>				DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 8-10-87						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen J. Noga	22e. ADDRESS 6001. Wolfe St., Baltimore MD															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8/12/87	23c. NAME OF CEMETERY OR CREMATORIAL New Cathedral			23d. LOCATION CITY OR TOWN Balto.			COUNTY			STATE MD					
24. FUNERAL DIRECTOR NAME H.W. Jenkins & Sons Co.	25a. DATE REC'D. BY REGISTRAR AUG 11 1987			25b. REGISTRAR'S SIGNATURE <i>John B. Jenkins</i>												

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23283

063434 AUG 24 1987

FOR
- STATE
REGISTRAR

REG. NO.

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

20. DATE OF DEATH MONTH DAY YEAR
08 19 872b. HOUR
5-10 AM

GERALD WAYNE VENNARD

1. SEX

male

1. RACE
white

5. DATE OF BIRTH

MONTH 9 DAY 2 YEAR 35

6. AGE IN YEARS LAST BIRTHDAY

51
YRS.

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a. BIRTHPLACE
COUNTRY
PA.7b. CITIZEN OF WHAT COUNTRY?
U.S.A.8. MARRIED NEVER MARRIED
WIDOWED DIVORCED 9. BALTIMORE CITY OR COUNTY OF DEATH
BALTIMORE

MD.

10 CITY OR TOWN OF DEATH
BALTIMORE11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ST. AGNES Hospital12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Photographer12b. KIND OF BUSINESS OR
INDUSTRY
Dept of Army13a. STATE
MD.13b. COUNTY
A.A.13c. CITY OR TOWN
HANOVER13d. INSIDE CITY LIMITS?
YES NO 13e. STREET ADDRESS
7407 Locust DRIVE 21076

14. FATHER'S NAME

Raymond

MIDDLE

LAST

Vennard

15. MOTHER'S MAIDEN NAME

Mary

MIDDLE

LAST
Hillard16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)

16b. IF YES, GIVE WAR OR DATE(S)

Yes

58-602

16c. SOCIAL SECURITY NO.
164-30-6635

17. INFORMANT

Dorothy Skinner #13e

ADDRESS

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) METASTATIC ADENOCARCINOMA.

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)	YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>

21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
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22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 8/19 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	21g. DEGREE	22b. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 8/19/87
--	-------------	---	-----------------------------

22d. PHYSICIAN'S NAME (TYPE OR PRINT) PILLAI, LATHA.	22e. ADDRESS St Agnes Hospital.
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-22-87	23c. NAME OF CEMETERY OR CREMATORIUM McKean Memorial	23d. LOCATION CITY OR TOWN Bradford	23e. COUNTY State PA
24. FUNERAL DIRECTOR NAME T. A. Hardisty	ADDRESS Ann. Md. 21401	25a. DATE REC'D. BY REGISTRAR AUG 20 1987	25b. REGISTRAR'S SIGNATURE Julie Bender-Randall	

003131 VHS TAPE

VHS TAPE

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then place in proper carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 23284			
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR G-D-P-M			
DECEASED NAME (TYPE OR PRINT)			FIRST Edna	MIDDLE Mildred	LAST Venturella	August 25, 1987							
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR July 20, 1898			6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD				
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty Medical Center			12a. USUAL OCCUPATION Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Own Home				
13. STATE Florida			13c. COUNTY Broward			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 8301 N.W. 58th Street 33313				
14. FATHER'S NAME FIRST Louis			MIDDLE Milton			LAST Wheatley			15. MOTHER'S MAIDEN NAME FIRST Mary			LAST E. Wilson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NA			17. INFORMANT (Son) S. Basil Duncan			ADDRESS 606 Brian Street Balto., Md. 21225				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro-vascular accident</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Sepsis</i> DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Anemia - clots</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 81251			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) examined the deceased from <u>7/16/87</u> , 19 <u>87</u> , to <u>8/1/87</u> , 19 <u>87</u> ; that (I) (we) last saw the deceased alive on <u>8/1/87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 8/28/87.			
22b. SIGNATURE <i>R. M. Shah MD</i>			DEGREE							ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R. M. Shah</i>			22e. ADDRESS LIBERTY Medical Center LIBERTY HT ME Baltimore MD										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug 29, 1987			23c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge Cemetery			23d. LOCATION CITY OR TOWN Pikesville			COUNTY Balto. Maryland	
24. FUNERAL DIRECTOR NAME Singleton Funeral Home			ADDRESS Glen Burnie, Maryland			25a. DATE REC'D. BY REGISTRAR AUG 28 1987			25b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Landale</i>				

10 16 2012 26240

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH2320
23285

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Noah L. Via						8-4-87				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male		Caucasian		2-15-23		64 YRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD		
Virginia		U.S.A.				Baltimore City				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore		2324 Washington Blvd.		Ret - Self-		Employed				
13a. STATE Maryland		13b. COUNTY Balto. Cit		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 21230		
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME Clara Garrison		LAST		
Daniel Via						16b. SOCIAL SECURITY NO. 189-18-5178		17. INFORMANT Mrs. Louise Via 2324 Washington Blvd.		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		18a. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate		18b. DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure 10 years		18c. DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery disease 20 years				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a hyperlipidemia.										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 8/1/1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from since the deceased died on 8/1/1987, and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I will not (did not) view the body after death.)		22b. SIGNATURE Joe Adams MD		22c. DEGREE		22d. DATE SIGNED 8/6/82				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Joe Adams MD		22f. ADDRESS 2521 Washington Blvd. Balto. 21230		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 8-7-87		23c. NAME OF CEMETERY OR CREMATORIAL Hummelstown Cem.		23d. LOCATION CITY OR TOWN		COUNTY STATE		
24. FUNERAL DIRECTOR NAME		Loring Byers Funeral Directors, Inc 8728 Liberty Road Randallstown Maryland 21133		25. DATE REC'D. BY REGISTRAR AUG 07 1987		26. P.D.'S SIGNATURE Julia Loring-Baddele PA				

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1010UA

20120

2 3 2 8 6

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL, IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 4A. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 4 AND 5 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2e. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR				
Marlene				BESSIE	Vinson		<input checked="" type="checkbox"/>	8/ 29/ 19	87						
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 38 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR				
F	B	12 10 48					8/ 29/ 19	87		6:05					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				7c. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				7d. DATE OF DEATH BALTIMORE CITY OR COUNTY OF DEATH			
MD				U.S.A.								Baltimore City, MD			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore				127 S. Exeter St.				UNEMPLOYED				N/A			
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
MD				BALTO.								127 S. EXETER STREET 21202			
14. FATHER'S NAME FIRST				MIDDLE				LAST				15. MOTHER'S MAIDEN NAME FIRST		LAST	
CLINTON								VINSON				ERNESTINE		ALSTON	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
NO								JOYCE WARREN				1917 WINDER ROAD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Narcotic intoxication												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.												DUE TO, OR AS A CONSEQUENCE OF			
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c) DUE TO, OR AS A CONSEQUENCE OF															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?							
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 8 29 19 87				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject used drugs.							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home				21f. LOCATION STREET CITY OR TOWN 127 S. Exeter Street Baltimore				COUNTY Maryland		STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>															
ACTUAL SIGNATURE <i>John E. Smialek</i> TITLE (SPECIFY) M.D. Chief MEDICAL EXAMINER															
EXAMINER'S NAME (TYPE OR PRINT) John E. Smialek, M.D. ADDRESS 111 Penn St., Balto., Md. 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORIUM				23d. LOCATION CITY OR TOWN ANNE ARUNDEL CO.,			
BURIAL				9/3/87				CEDAR HILL CEMETERY				COUNTY MD			
24. FUNERAL DIRECTOR NAME <i>W.M. C. March F/H, Inc.</i> ADDRESS 1101 E. NORTH AVENUE DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>REPO 2 1987</i>															
07/84 BP 749 DHMH - 17 (VR A15 ME (5))		25a. DATE REC'D. BY REGISTRAR													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be
reached by the hospital or attending physician.

6

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove stamp from Part 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner and/or the medical director should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23287

1 - FOR STATE REGISTRAR			REG. NO.									
DECEASED NAME FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR						
DONALO R. VIRGIL			8 18 87			5:45 PM						
3. SEX: Male		4. RACE: White		5. DATE OF BIRTH: MONTH 12 DAY 9 YEAR 19			6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b. CITIZEN OF WHAT COUNTRY? USA		7c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH- Baltimore City			MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital		12a. USUAL OCCUPATION Retired			12b. KIND OF BUSINESS OR INDUSTRY Controller					
13a. STATE Md.		13b. COUNTY Howard		13c. CITY OR TOWN Columbia			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 5017 Durham Rd. 21044		
14. FATHER'S NAME FIRST George		MIDDLE		LAST Virgil			15. MOTHER'S MAIDEN NAME FIRST Bernice			MIDDLE LAST Warman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II		17. INFORMANT Irma Virgil			ADDRESS 5017 Durham Rd. 21044			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Sudden Death</i>												
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute Myocardial Infarction</i>												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Coronary Artery Disease</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <i>Hypertension; Diabetes Mellitus; History of smoking</i>												
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> N/A				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> TO DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>None</i>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) <i>N/A</i>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, NEIGHBORHOOD, FARM, ETC.) <i>N/A</i>			21f. LOCATION STREET <i>N/A</i>			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (i) (this hospital) attended the deceased from NOVEMBER 19 80 to Aug 18 19 87, that (ii) (we) last saw the deceased alive on FEB 17 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) did not view the body after death.												
22b. SIGNATURE <i>Randy L. Reese, MD</i>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 8/19/87				
22e. ADDRESS <i>2850 N. Ridge Rd, ELLICOTT CITY MD 21043</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/21/87		23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Cemetery			23d. LOCATION CITY OR TOWN Balti. County Md.			STATE		
24. FUNERAL DIRECTOR HARRY H WITZKE & FAMILY FUNERAL HOME, INC.		4112 OLD COLUMBIA PIKE ELLICOTT CITY MD 21043			25a. DATE REC'D. BY REGISTRAR AUG 20 1987			25b. REGISTRAR'S SIGNATURE <i>Julia Barber-Ladouceur</i>				
DHMH - 16 60M 7/84 (VRA 15, 4)												

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be initialed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please enter the State Death of Health and Mental Hygiene form. Pages 1 and 2 should be filed within 72 hours after death. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or either traumatic or nontraumatic, medical examination of the deceased must be performed.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	26. HOUR	
RONALD A. VIRGIN					X	8	1	47	X 8 ⁴⁷ P.M.		
1. SEX	M	4. RACE	B	5. DATE OF BIRTH	MONTH JUN	DAY 23	YEAR 48	6. AGE (IN YEARS LAST BIRTHDAY)	39	IF UNDER 1 YEAR MONTHS YRS	IF UNDER 72 HRS HOURS MIN.
7a. BIRTHPLACE (COUNTRY)	Md.	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8.	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH City					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) X FRANCIS SCOTT KEY HOSP			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance					
13a. STATE	Md.	13b. COUNTY	Balto	13c. CITY OR TOWN	Turners Station	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 135 Fleming Dr. 21222				
14. FATHER'S NAME	Robert	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME	Sadie	MIDDLE	LAST	12b. KIND OF BUSINESS OR INDUSTRY Edmonds			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No	16b. SOCIAL SECURITY NO.	214-50-5563	17. INFORMANT	ADDRESS Frances Allmond 213 Main St. 21222						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SEPSIS											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE						
22a. I certify that (I) (this hospital) attended the deceased from 7-11, 19 87, to 8-1, 19 87, that (I) (we) last saw the deceased alive on 8-1, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE 			DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED X 8-1-87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) X B. LEPP			22e. ADDRESS X FRANCIS SCOTT KEY HOSP								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE Burial 8-5-87	23c. NAME OF CEMETERY OR CREMATORIAL Arbutus	23d. LOCATION CITY OR TOWN Balto.	COUNTY	STATE						
24. FUNERAL DIRECTOR NAME Jas. A. Merton & Sons	ADDRESS 1701 Laurens St.	25a. DATE REC'D. BY REGISTRAR AUG 05 1987		25b. REGISTRAR'S SIGNATURE Julie Dawson-Landale							

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 2 3 2 8 9
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

064724 SEP -4-87

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1-2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER. PAGES 1-2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI. DEATH MATED				MONTH	DAY	YEAR	2b. HOUR	
Lawrence				J.		Vogel 3rd	<input checked="" type="checkbox"/>				8	26	1987	M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	MONTHS DAYS HOURS MIN					2c. DATE PRONOUNCED DEAD				
Male	White	4/8/1949	38 yrs.								8	26	1987	M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED	<input type="checkbox"/> NEVER MARRIED	<input checked="" type="checkbox"/>	WIDOWED	<input type="checkbox"/> DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA								Baltimore City					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OR WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore		University Hospital			Balto. Md			Laborer				Self			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		21227						
Maryland		Balto.		Baltimore			3131 Bero Rd. Balto. Md.								
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST								
Lawrence		J.	Vogel, Jr.	Ethel		---	Fabian								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS								
Yes Vietnam		218-48-1784			Sandra M. Carlile, Same as above										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fatty liver													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last</u> . (b) Chronic alcoholism															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20d. AUTOPSY?										
					HEAD & ABDQ. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													DATE SIGNED		
ACTUAL SIGNATURE		MARIO F. GOLLE, JR.			TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER							8/26/87	
EXAMINER'S NAME (TYPE OR PRINT)		Mario F. Golle, jr, M.D.			ADDRESS		111 Penn St.							Balto. MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		COUNTY		STATE					
Burial		9/4/1987		Crownsville, V.A. Cemt.		Crownsville, Md.									
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE										
McCully Funeral Home, 130 E. Fort Ave.		SEP 3 1987			Julia Davidson-Randall										

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23290

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
STEFANIJA VYSNIAUSKAS						AUGUST	27,	1987		2:49PM	
3. SEX			4. RACE		5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)					
FEMALE			WHITE		MONTH 10 DAY 2 YEAR 02	84					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
LITHUANIA			LITHUANIA					BALTIMORE CITY			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE			CHURCH HOME AND HOSPITAL		SEAMSTRESS			John Draunias Tailor Shop			
13a. STATE MARYLAND			13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2124 E. PRATT STREET 21231			MD.	
14. FATHER'S NAME FIRST KAZYS			MIDDLE	LAST IGNATAVICIUS	15. MOTHER'S MAIDEN NAME FIRST SOPHIA		MIDDLE	LAST JANKAUSKAS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS				
NO			216-30-8161		JONAS VYSNIAUSKAS		2124 E. PRATT ST. 21231				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ischemic Heart Disease.											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) Aortic stenosis - Severe											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (this hospital) attended the deceased from 8/25, 1983, to 8/27, 1987, tht (we) last saw the deceased alive on 8/25, 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I/we) did (did not) view the body after death.											
22b. SIGNATURE m. welinsky			DEGREE m. d.		ATTENDING PHYSICIAN	<input checked="" type="checkbox"/> DIRECTOR	<input type="checkbox"/> STAFF PHYSICIAN	22c. DATE SIGNED 8/28/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) m. welinsky			22e. ADDRESS 2323 orLean's Street								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 8/31/87	23c. NAME OF CEMETERY OR CREMATORIAL LOUDON PARK CEM.			23d. LOCATION BALTIMORE	23e. COUNTY BALTIMORE	23f. STATE MARYLAND		
24. FUNERAL DIRECTOR 4107 ^{ME} WILKENS AVENUE HUBBARD FUNERAL HOME, INC.			ADDRESS 21229			25a. DATE REC'D. BY REGISTRAR AUG 31 1987			25b. REGISTRAR'S SIGNATURE Julia Steiner		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, sign page 2 and page 3 should be held within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be informed.

BP _____

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Page 21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										23291			
1 - STATE REGISTRAR			REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Florence Emily Wagner							August 4, 1987						
3. SEX			RACE	S. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female			white	MONTH	DAY	YEAR	63	MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., MD			7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City								
10. CITY OR TOWN OF DEATH Balto. City			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2808 Westfield Ave., Balto. 21214			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE MD			13b. COUNTY	13c. CITY OR TOWN Balto. City	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2808 Westfield Ave., Balto. 21214						
14. FATHER'S NAME FIRST Edward			MIDDLE	LAST Wagner	15. MOTHER'S MAIDEN NAME FIRST Dora								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 215-24-0159		17. INFORMANT Michael, J. Dausch, III, 6741 Glenkirk Rd.		ADDRESS Balto. MD 21239			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>coronary atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from 19 50 to Aug 4, 19 87, that (I) (we) last saw the deceased alive on December 10 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.													
22b. SIGNATURE <u>Donald Jancoff</u>			22c. DATE SIGNED 8-7-87		DEGREE M.D.	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Donald Jancoff</u>			22e. ADDRESS 7403 Harford Rd.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-8-87	23c. NAME OF CEMETERY OR CREMATORIAL Moreland Memorial		23d. LOCATION CITY OR TOWN Balto.		COUNTY	MD	STATE			
24. FUNERAL DIRECTOR NAME John C. Miller, Inc., 6415 Belair Rd., 21206					25a. DATE REC'D. BY REGISTRAR AUG 7 1987		25b. REGISTRAR'S SIGNATURE <u>Lia Jancoff</u>						

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Indicates date of 1863. The date is written in ink.

063246
AUG 20 87.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by an attending physician or retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by an attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. The original remains should be forwarded to the funeral home, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner may be notified.

FOR DOLORES CECELIA WALKER				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 23292					
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
DELORES				WALKER	AUGUST 17, 1987				9:55P M				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE		WHITE		10 MONTH 24 DAY 1924 YEAR		62		YRS.		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.					
MARYLAND		USA				BALTIMORE CITY							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE		THE JOHNS HOPKINS HOSPITAL				HOUSEWIFE				HOME			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		2120b			
MD		BALTO		BALTO		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5532 McCORMICK AVE					
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST				
JOSEPH		ANDREW		REITZ	HELEN		SIN		SINSKY				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO		n/a		218142930		SHARON WALKER 116 HASTINGS CT 21009				one week			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia one week Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (c) Refractory Acute LYMPHOBLASTIC Leukemia one year													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <i>Infiltrating Ductal Breast Carcinoma</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from August 8, 1987, to August 17, 1987, that (I) (we) last saw the deceased alive on August 17, 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Daniel L. Clemens, MD, PhD</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/17/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Daniel L. Clemens, MD, PhD</i>		22e. ADDRESS 600 N. Wolfe St., Baltimore, MD 21205											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 08/21/87		23c. NAME OF CEMETERY OR CREMATORIAL ST. STANISLAUS		23d. LOCATION CITY OR TOWN BALTO		COUNTY		STATE MD			
24. FUNERAL DIRECTOR NAME <i>Bethany Walker</i>		ADDRESS 1211 Clifton Ave.		25a. DATE REC'D. BY REGISTRAR AUG 19 1987		25b. REGISTRAR'S SIGNATURE <i>Julie Dearden Pendleton</i>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2a is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

Item 13e Film G630 31-87 8-31-87 I.J. REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				2 3 2 9 3			
1 DECEASED NAME (TYPE OR PRINT) JOHN L. WALKER SR.				2a DATE OF DEATH MONTH DAY YEAR 8-21-87				2b HOUR 240 PM			
3 SEX MALE		4 RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 7 8 28		6 AGE (IN YEARS LAST BIRTHDAY) 59 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE COUNTRY VA		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY		MD.			
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL		12a USUAL OCCUPATION (TYPE OR PRINT FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY POST OFFICE					
13a STATE MD		13b COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 821 CATOR AVENUE 21218		3533 Old York RD.	
14. FATHER'S NAME FIRST PETER		MIDDLE WALKER		15. MOTHER'S MAIDEN NAME FIRST MARY		MIDDLE		LAST SPENCER			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) YES ARMY 225-22-7054		17 INFORMANT FRANCES HUDSON 821 CATOR AVENUE		ADDRESS					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Oat Cell Carcinoma of Lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 19a DATE OF OPERATION 19b CONDITION FOR WHICH OPERATION WAS PERFORMED 70b AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>8/21</u> , 19 <u>87</u> , to <u>8/21</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>8/21</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Oresky</u>		22c. DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYSICIAN X		22d. DATE SIGNED 8/21/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Oresky</u>		22e. ADDRESS Union Memorial Hospital									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/28/87		23c. NAME OF CEMETERY OR CREMATORIUM GARRISON FOREST CEM.		23d. LOCATION CITY OR TOWN OWINGS MILLS		23e. COUNTY MD		23f. STATE MD	
24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H		ADDRESS 1101 E. NORTH AVENUE 21202		25a. DATE RECEIVED BY REGISTRAR AUG 27 1987		25b. REGISTRAR'S SIGNATURE <u>La Davidson-Pender</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and retained by the hospital or attending physician, it should be detached for use on the burial/transit permit. Then please remove carbon paper, page 3, and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certifier must be included or attach.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 23294			
1. STATE REGISTRAR			2. DATE OF DEATH			2b. HOUR			
NAME (TYPE OR PRINT)			MONTH	DAY	YEAR	8:30 A.M.			
FIRSt MARIE			MIDDLE WALTER	LAST WALLACE	August 24, 1987				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 15, 1921		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 66 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3 St. Martins Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3 St. Martins Rd., 21218	
14. FATHER'S NAME FIRST J. Stuart		MIDDLE Walter		LAST Marie		15. MOTHER'S MAIDEN NAME Webb			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) No 218 12 2207		17. INFORMANT David Wallace, Jr., Same		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Respiratory Arrest				APPROXIMATE INTERVAL BEWEEN ONSET AND DEATH immt			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		{ Repeated strokes				X 6 weeks			
(b)		DUE TO, OR AS A CONSEQUENCE OF							
(c)		DUE TO, OR AS A CONSEQUENCE OF							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Muscle Sclerosis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/24/87 to 8/24/87, that (I) (we) lost saw the deceased alive on 8/24/87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not) view the body after death.									
22b. SIGNATURE Dr. Stuart B. Bell, MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/24/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Stuart B. Bell, MD		22e. ADDRESS 3501 St. Paul St., Balto., MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8/25/87		23c. NAME OF CEMETERY OR CREMATORIAL Green Mount		23d. LOCATION CITY OR TOWN Balto., MD			
24. FUNERAL DIRECTOR NAME H.W. Jenkins		ADDRESS 21212		25a. DATE REC'D. BY REGISTRAR AUG 25 1987		25b. REGISTRAR'S SIGNATURE			

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Page 4 may be

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and should be filed in by the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial or cremation.

BP _____
DHMH - 16 60M 7/B4
(VRA 15, 4)FOR
STATE
REGISTRAR
1381STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23295

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BETTY JANE WALLS			FIRST	MIDDLE	LAST	2b. DATE OF DEATH 8/19/87	MONTH	DAY	YEAR	2b. HOUR 10 19 M		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH 12 DAY 31 YEAR 1932			6. AGE (IN YEARS LAST BIRTHDAY) 54	IF UNDER 1 YEAR -	MONTHS	DAYS	HOURS	MIN.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY						
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker							
13a. STATE Maryland		13b. COUNTY Balto. City Baltimore		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4400 Falls Road 21211				
14. FATHER'S NAME FIRST Clarence		MIDDLE Gibson	LAST	15. MOTHER'S MAIDEN NAME FIRST Rebecca		MIDDLE	LAST Baker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (TYPE NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-30-3350		17. INFORMANT		ADDRESS Betty J. Varkus 925 Day Rd. 21784						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory seizure. DUE TO, OR AS A CONSEQUENCE OF (b) ④ pneumonectomy per lung Cancer APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 hr. { DUE TO, OR AS A CONSEQUENCE OF (c) Infection.												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Cardiac instability												
19a. DATE OF OPERATION 7/21/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED LIL squamous cell Ca.			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>												
22a. I certify that (I) this hospital attended the deceased from Aug 1 , 19 87 , to Aug 8 , 19 87 , that (we) lost soul the deceased alive on Aug 9 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We did not view the body after death.)												
22b. SIGNATURE Cornelius Stamp		22c. DEGREE			22d. DATE SIGNED Aug 9 1987		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Cornelius Stamp		23c. NAME OF CEMETERY OR CREMATORIAL UNION MEMORIAL HOSPITAL			23d. LOCATION CITY OR TOWN Baltimore Maryland		23e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/13/1987		23c. NAME OF CEMETERY OR CREMATORIAL Lorraine Park Cem.		23d. LOCATION CITY OR TOWN Baltimore Maryland		23e. ADDRESS		25a. DATE REC'D. BY REGISTRAR AUG 12 1987		
24. FUNERAL DIRECTOR NAME Burgee-Henss Funeral Home		ADDRESS 3631 Falls Road			25b. REGISTRAR'S SIGNATURE John G. Henderle							

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1909 COTTON FIELD



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

reigned by the hospital or attending physician.

Page 4 may be

completely filled in by the funeral director. Page 3
should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 2 should be used with 24 hours of death.

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23295

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>Agnes</i>			<i>M.</i>	<i>WARD</i>		<i>Aug. 21</i>	<i>87</i>				
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female	White	MONTH	DAY	YEAR	64	MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH	MD.					
Maryland	USA				Baltimore City						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	1243 Glyndon Avenue					Homemaker					---
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
Maryland	---	Baltimore				1243 Glyndon Avenue, 21223					
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
Albert			Sickle	Lorena					Norris		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No	216-12-0722			Ronald J. Ward, 1731 Inverness Avenue							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Renal Failure</i>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Circumstances of illness with metastases</i>											unknown
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>8/15/87</i> to <i>8/20/87</i> , that <input checked="" type="checkbox"/> (I/we) last saw the deceased alive on <i>N/A</i> 19 <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (did not) view the body after death.											22c. DATE SIGNED <i>8/21/87</i>
22b. SIGNATURE <i>Alfred J. Daniels</i>		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Alfred J. Daniels</i>		22e. ADDRESS <i>Washington Village Medical Center</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE 8/24/87		23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery			23d. LOCATION CITY OR TOWN Baltimore		COUNTY	STATE Maryland	
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.		ADDRESS 4107 Wilkens Ave.			25a. DATE REC'D. BY REGISTRAR <i>AUG 24 1987</i>		25b. REGISTRAR'S SIGNATURE <i>John R. Daniels</i>				

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23297

063820 AUG 25 87

FOR
STATE
REGISTRAR

Sb Per Funeral home

REG. NO.

1 - DATE OF DEATH (MONTH DAY YEAR)			2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
<i>Callean WARE</i>			8 17 87	13 ⁴⁵ /6 PM
3 SEX <i>FEMALE</i>		4 RACE <i>Black</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>1-24-1897</i>	6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i>
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <i>South Baltimore General Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>21225</i>
13. STATE <i>MARYLAND</i>		13b. COUNTY <i>A. A. BALTIMORE</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	12b. KIND OF BUSINESS OR INDUSTRY <i>223 CEDARHILL NAME</i>
14. FATHER'S NAME FIRST <i>Russell</i>		MIDDLE <i>W. Williams</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Mary</i>	MIDDLE <i>Jones</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <i>212363130</i>	17. INFORMANT <i>C G Brooks</i>	ADDRESS <i>211 Cedar Hill Lane</i>
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio genic Shock</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Myocardial Infarction</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 hrs</i>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN
				COUNTY STATE
22a. I certify that (1) (his hospital) attended the deceased from <i>8-17 1987</i> to <i>8-17 1987</i> , that (1) (we) last saw the deceased alive on <i>8-17 1987</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (2) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>Dan Wenberg</i>		22c. DEGREE	22d. DATE SIGNED <i>8/17/87</i>	
22e. ADDRESS <i>3001 S. Hanover ST</i>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Aug. 21, 87</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt Calvary</i>	23d. LOCATION CITY OR TOWN <i>A. A. County Md.</i>
24. FUNERAL DIRECTOR NAME <i>Oden & Gibson</i>		25a. ADDRESS <i>1631 Ward H. II Av.</i>	25b. DATE REC'D. BY REGISTRAR <i>AUG 21 1987</i>	25c. REGISTRAR'S SIGNATURE <i>Julia Sanderson-Randall</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the physician indicate he was executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the certifying physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transcript permit. Then please return carbon copy to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 22 shows any injury or other traumatic event, the medical examiner must be notified at once.

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South African J. Agric.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

23298

064550

SEP-2-87

1- STATE
REGISTRAR

REG. NO.

1-CODED NAME (INT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	<input checked="" type="checkbox"/> MONTH	DAY	YEAR	2b. HOUR			
Latrea		A.		Washington	<input checked="" type="checkbox"/>	8/20/1987			M			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR 3:00 A.M.		
Female	Negro	2-14-87	6 6			8/20/1987						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH						
Baltimore Md		U.S.A.		<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		Baltimore City						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore		University Hospital				Baby						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
Maryland				Baltimore		NO		518 DOLPHIN ST 21201				
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST					
James Washington				Renée Robinson								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						
No						Miss Renée Robinson 518 Dolphin St 21201						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) _____												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which goe rise to immediate cause (a) stating the under- lying cause lost.												
(b) _____												
DUE TO, OR AS A CONSEQUENCE OF												
(c) _____												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?						
						<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE		Dennis F. Smyth, M.D.				TITLE (SPECIFY) Assistant					DATE SIGNED	
EXAMINER'S NAME (TYPE OR PRINT)		Dennis F. Smyth, M.D.				MEDICAL EXAMINER					8/20/87	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL				23d. LOCATION CITY OR TOWN			23e. COUNTY	
CREMATION		8-21-87		WESTVIEW MEM PK				Balto., Co., Md.			STATE	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Joseph L. Russ		111 Penn St., Balto., Md. 21201		AUG 31 1987		Julia Sander-Landau						

004220 022180
185-932 022180



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-trousser permit. Then please remove carbon paper with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, no medical examination may be made.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23299

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	26 DATE OF DEATH	MONTH	DAY	YEAR	26 HOUR		
Sarah			F.		Washington	8/30/87				3:39 A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
female		black		MONTH	DAY	YEAR	80			MONTHS	YEARS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
LA		USA						Baltimore City,				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore		Union Memorial Hospital										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE				
Md		AA		Severn		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1941 Stone Castle Drive 21144				
14. MOTHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST					
Neal			Clarke	Elizabeth			Pearson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT		ADDRESS					
No		213-12-3606			Lindsay Washington, Jr		1941 Stone Castle Dr.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Probable Arrhythmia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Diabetic Nephropathy, Hemiparesis, S/P urosepsis</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1, OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/19</u> , 19 <u>87</u> , to <u>8/30</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>8/30</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE		DEGREE			22c. DATE SIGNED							
Wendie A. Berg MD					8/30/87							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										
Wendie A. Berg, M.D.		Union Memorial Hospital										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION CITY OR TOWN		23e. STAFF ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				
Burial		9/4/87	Mt Calvary Cemetery			Anne Arundel Co		MD				
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Wm. C. March F/H West 4300 Wabash Avenue					SEP 2 1987		<u>Lia Sneider Landau</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filed in by the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy from page 2 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of body.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 23300					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH MONTH DAY YEAR	2b HOUR			
Camilie Rita Waskey						1 8-23-87	10:00 A.M.			
2. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				
FEMALE		White		MONTH	DAY	YEAR	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
BALTO.		U.S.A.				BALTIMORE CITY MD				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		ST. AGNES HOSPITAL					HOUSEWIFE		HOUSEWIFE	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		
MD		BALTIMORE		Catonsville				6114 EDMONDSON AVE. 21228		
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME					
Stanislaus				KOWALSKI	FIRST Pelagia				LAST Wesolowski	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO		214501619		Mr. Michael V. Waskey/ Galesville, MD 20765		4878 Captains Ct.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mycocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO, OR AS A CONSEQUENCE OF										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from 8-20-87 to 8-23-87, that (II) (we) last saw the deceased alive on 8-23-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS								
S. G. Lee, MD		St. Agnes Hospital								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		COUNTY STATE		
Burial		8-25-1987		Glen Haven Cemetery		Glen Burnie A.A. Md.				
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR TO REGISTRAR'S SIGNATURE								
ROBERT S. BARRANCO		AUG 28 1987 S. J. Wilson, R.R.								
SEVERNA PARK, MD. 21146										

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BEVERLY HILLS CALIFORNIA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 2330
1 - STATE REGISTRAR	FIRST <u>Susie</u>	MIDDLE <u>T.</u>	LAST <u>Waters</u>	2d. DATE OF DEATH MONTH DAY YEAR 2d HOUR <u>August 4 1987 11 p.m.</u>
3. SEX <u>Female</u>	4. RACE <u>Black</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>March 15, 1915</u>	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS <u>72 yrs</u>	IF UNDER 24 HRS MONTHS HOURS MIN. <u> </u>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Va</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City MD</u>	
10. CITY OR TOWN OF DEATH <u>Baltimore</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Liberty Medical Center</u>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Unemployed</u>	12b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
13a. STATE <u>Md</u>	13b. COUNTY <u>Baltimore</u>	13c. CITY OR TOWN <u>Baltimore</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <u>3636 Dorfield Ave 21215</u>
14. FATHER'S NAME FIRST <u>James</u>	MIDDLE <u></u>	LAST <u>Taylor</u>	15. MOTHER'S MAIDEN NAME FIRST <u>Emma</u>	MIDDLE <u></u>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>224-07-7841</u>	17. INFORMANT <u>Paul Taylor</u>	ADDRESS <u>3636 Dorfield Ave</u>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u> </u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Infected Decubitus Ulcer</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral Vascular Disease</u>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>Chronic Renal Failure; Dementia;</u>				
19a. MEDICAL CERTIFICATION DATE OF OPERATION <u>9/9/99</u>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u></u>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u> </u>	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u> </u>		
21d. INJURY OCCURRED WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u> </u>	21f. LOCATION STREET <u> </u>	CITY OR TOWN <u> </u>	
22a. I certify that (I) (this hospital) attended the deceased from <u>July 2</u> 19 <u>87</u> , to <u>Aug 4</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>Aug 4</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	22b. SIGNATURE <u>David Sung</u>	DEGREE <u>MD</u>	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> DATE SIGNED <u>4 August 1987</u>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <u>David Sung</u>	22e. ADDRESS <u> </u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b. DATE <u>8/7/87</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Arbutus Mem Park</u>	23d. LOCATION CITY OR TOWN <u>Arbutus</u>	
24. FUNERAL DIRECTOR NAME <u>Wm. C. March F/H West 4300</u>	ADDRESS <u>Wabash Avenue</u>	25a. DATE REC'D. BY REGISTRAR <u>AUG 06 1987</u>	25b. REGISTRAR'S SIGNATURE <u>Julia Scidmore-Lindner</u>	

168-32A CCC180

4/20/74 H

100% 100%

normal

normal except for some

slight discoloration

168-32A CCC180

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Please sign and date this certificate and file it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	23302			
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
James Watkins										8	1	87	7:20 AM	
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Male	Black	MONTH	DAY	YEAR	58	YRS.	MONTHS	DAYS	HOURS	MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Baltimore	USA	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Bart. City									
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Bart. city	Univ. of MD. Hosp													
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			21223					
MD	Baltimore	Baltimore	YES <input type="checkbox"/> NO <input type="checkbox"/>			1217 W. Fayette St			21223					
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST	Rebecca Happis				
James			Watkins	Rebecca						Rebecca Happis				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
NO		Rebecca			Rebecca Hale 11683 Frederickway North			8/1/87						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)														
cardiopulmonary arrest														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF sepsis / perforation of colon														
(c) DUE TO, OR AS A CONSEQUENCE OF underlying metastatic colon ca.														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
8/1/87	perforated bowel	YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) UMH RR	21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE							
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 8/1/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.	22b. SIGNATURE Jacque	22c. DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED 8/1/87								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jacque	22e. ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Aug 3, 1987	23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park	23d. LOCATION CITY OR TOWN Baltimore											
24. FUNERAL DIRECTOR NAME Kedd Funeral Home	ADDRESS 5209 York Rd	25a. DATE REC'D. BY REGISTRAR AUG 5 1987	25b. REGISTRATION NUMBER See Footer											

062012 WUE-B81

WUE-B81

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23303

REG. NO.

I. DECEASED NAME (TYPE OR PRINT)				FIRST SHARLYN	MIDDLE Amey	LAST WATKINS	2a DATE OF DEATH AUGUST 11, 1987	MONTH YEAR 12:30 PM	2b HOUR
3. SEX Female		4 RACE White	5. DATE OF BIRTH MONTH 08 DAY 06 YEAR 87	6. AGE (IN YEARS LAST BIRTHDAY) 0 yrs.		IF UNDER 1 YEAR MONTHS 5		IF UNDER 24 HRS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) -----		12b. KIND OF BUSINESS OR INDUSTRY -----		
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Arbutus	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5524 Thomas Ave. 21227				
14. FATHER'S NAME FIRST Michael S. Watkins		MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST Cynthia Harrison		MIDDLE	LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) -----		16b. SOCIAL SECURITY NO. -----	17. INFORMANT Michael S. Watkins		ADDRESS 5524 Thomas Ave. 21227				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SEPSIS 1 MINUTE							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) MIDGUT VOLVULUS AND							
		DUE TO, OR AS A CONSEQUENCE OF (c) ALMOST COMPLETE BOWEL INFARCTION							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None									
19a. DATE OF OPERATION 8/18 + 8/19/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED EXP LAP FOR MIDGUT VOLVULUS			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Aug 8 , 19 1987 , to Aug 11 , 19 1987 , that (I) (we) lost saw the deceased alive on Aug 11 , 19 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Ambrose Wond</i>		22c. DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Jackson Wond</i>		22e. ADDRESS John Hopkins Hospital		22f. DATE SIGNED 8/11/87					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 08/14/87		23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Cemetery		23d. LOCATION CITY OR TOWN Dorsey		23e. COUNTY Howard	
24. FUNERAL DIRECTOR NAME Ambrose Funeral Home		ADDRESS 1328 Sulphur Spring Rd		25a. DATE REC'D. BY REGISTRAR AUG 12 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Scidmore-Lunday</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 will be detached to use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other tragic event, the medical examiner must be notified.

085210 Aug 13 81

085210 Aug 13 81

064676 SEP -3 87

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18 GIVING GEST. 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 2. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGE 4 SHOULD BE USED AS A BURIAL-CREMATION, OR REMOVAL AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

23304

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR			
VIOLA			R.		WATSON	<input checked="" type="checkbox"/>	8	31	1987	M			
3. SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR			
female	black	3 5 1910	77			<input checked="" type="checkbox"/>	8	31	1987	9:04 A.M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH							
S.C.		U.S.A.		<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		Baltimore City							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore			1612 Ruxton Ave.			Retired							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS						
Md				Baltimore			1612 Ruxton Avenue 21216						
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			LAST					
Daniel				Henderson	Elizabeth			Williams					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No			212-30-6748			Thelma Baylor			3210 Vickers Road				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF													
(c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b).													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?				
									YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Margarita A. Korell</u> TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER													
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 111 Penn St., Balto., MD 21201										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE		
Burial			9/4/87	Md Nat Memorial Park			Laurel				Md		
24. FUNERAL DIRECTOR NAME			ADDRESS SEP 2 1987								25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Julia Sander-Randall</u>
Wm. C. March F/H			West 4300 Wabash Avenue								SEP 2 1987		

10 E - SEP 27 1961

REGISTRATION
NUMBER



10 E

10 E

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 3 5 0

FOR
1 - STATE
REGISTRAR

REG. NO.

BASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

2a. DATE KNOWN
OF
DEATH
ESTI-
MATED

MONTH

DAY

YEAR

7b. HOUR

Richard

L.

Waybright, Sr.

8/ 31 1987

M

3. SEX

4. RACE

5. DATE OF BIRTH

MONTH

DAY

YEAR

6. AGE (IN YEARS
LAST BIRTHDAY)

IF UNDER 1 YR.

IF UNDER 24 HRS.

MONTHS

DAYS

HOURS

MIN

7c. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

West Virginia

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED NEVER MARRIED
WIDOWED DIVORCED

2c. DATE
PRONOUNCED
DEAD

MONTH

DAY

YEAR

2d. HOUR

M

8/ 31 1987

a M

10. CITY OR TOWN OF DEATH

Baltimore

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Francis Scott Key Medical Center

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore City,

MD.

12. SUSTAINABLE RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Baltimore

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES

NO

13e. STREET ADDRESS

6527 Cleveland Ave. 21222

14. FATHER'S NAME

FIRST

MIDDLE

LAST

Bricel

WAYBRIGHT

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

Dolly

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
(IF YES, GIVE WAR OR DATES)

Yes

16b. SOCIAL SECURITY NO.

212-30-8341

17. INFORMANT

Eileen C. Waybright 6527 Cleveland Ave.

ADDRESS

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES

NO

21a. EXTERNAL CAUSE WAS

UNDERLYING OR
CONTRIBUTING CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M.

19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE NOT WHILE
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held on

Autopsy

Inspection

Inquiry

and in my opinion

death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE

TIME (SPECIFY)

M.D.

Assistant MEDICAL EXAMINER

DATE
SIGNED

8/3/87

EXAMINER'S NAME
(TYPE OR PRINT)

Dennis F. Smyth, M.D.

ADDRESS

111 Penn St.

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

8-6-87

23c. NAME OF CEMETERY OR CREMATORIUM

Holly Hill

23d. LOCATION
CITY OR TOWN

Baltimore Maryland

COUNTY

STATE

24. FUNERAL DIRECTOR
NAME

Duda-Ruck Funeral Home of Dundalk

7922 Wise Ave. Dundalk, MD 21222

AUG 5 1987

25. DATE REC'D. BY REGISTRAR
REGISTRAR'S SIGNATURE

061916 Aug 1981



062324 AUG 1187

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												2330				
												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH				MONTH	DAY	YEAR	2b. HOUR		
ANDREW						WEBB	AUGUST 5, 1987							8:27 MP		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		# UNDER 24 HRS			
MALE		BLACK		MONTH	DAY	YEAR	29				MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				BALTIMORE CITY					
NC		U.S.A.		THE JOHNS HOPKINS HOSPITAL			10. CITY OR TOWN OF DEATH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			BALTO.				SELF EMPLOYED				N/A			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE					
MD				BALTO.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				1208 WOODBOURNE AVE 21239					
14. FATHER'S NAME				FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME				FIRST	MIDDLE	LAST	PHIPPS		
CHARLIE				G.		WEBB	ENDIE									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)				17. INFORMANT				ADDRESS				
NO				238-98-6836				CASSANDRA R. WEBB				1208 WOODBOURNE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST												0-15 min				
DUE TO, OR AS A CONSEQUENCE OF (b) BRAIN ABSCESS												2 weeks				
DUE TO, OR AS A CONSEQUENCE OF (c) BACTERIAL ENDOCARDITIS												3 weeks				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED P.M.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED <small>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></small>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>July 29, 1987</u> to <u>August 5, 1987</u> , that <u>I</u> was present during the deceased's life on <u>August 5, 1987</u> , and that in my opinion death occurred on the date and hour and from the causes stated above. I further certify that <u>I</u> did not view the body after death.												22c. DATE SIGNED				
22b. SIGNATURE <u>Eric Brown MD</u>												DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS													
Eric Brown MD			600 N WOLFE ST BALTIMORE MD 21205													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY/TOWN				COUNTY			
BURIAL			8/12/87			PHIPPS FAMILY CEMETERY LITTLETON,							NO/CATE			
24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H, INC., 1101 E. NORTH AVE.												25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
												AUG 7 1987		<u>Jeanne Johnson</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the funeral director or attending physician. After this certificate has been signed by the attending physician and completed, it should be detached for use on the burial/transit permit. Then please remove carbon copies. Page 4 may be filed within 24 hours after death.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d DATE OF DEATH MONTH	DAY	YEAR	2b HOUR 24 PM
<i>Rebecca</i>					Weiss	8-18-87			
SEX F FEMALE	RACE Caucasian	5. DATE OF BIRTH MONTH 4 / DAY 18 / YEAR 1987	6. AGE (IN YEARS LAST BIRTHDAY) 71	IF UNDER 1 YEAR MONTHS YRS	IF UNDER 12 HRS HOURS 24				
7a. BIRTHPLACE COUNTRY MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY						
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY AT HOME						
13a. STATE MARYLAND	13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> XXX	13e. STREET ADDRESS / ZIP CODE 3 CROYDON CT. 21207					
14. FATHER'S NAME FIRST SOLOMON	MIDDLE	LAST MILLNER	15. MOTHER'S MAIDEN NAME FIRST DEENA	MIDDLE	LAST GOLDBERG				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-01-2591	16c. FORMANT DR. STANLEY A. WEISS	16d. ADDRESS 3 CROYDON CT. 21207	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Serousal hemorrhage</i>				10-15 yrs					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Hypertension</i>				10-15 yrs					
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerosis</i>				70 yrs					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <i>Diabetes Mellitus, decoupl Heart Disease & pulmonary edema</i>									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 28 1987</i> to <i>Aug 18 1987</i> , that (I) (we) last saw the deceased alive on <i>Aug 18 1987</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Jonas H. Cohen</i>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 8/19/87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JONAS H. COHEN	22e. ADDRESS 6707 Park Heights Ave. Baltimore MD 21215								
23a. BURIAL, CREMATION, REMOVAL BURIAL	23b. DATE 8-20-87	23c. NAME OF CEMETERY OR CREMATORIAL RODFE ZEDEK CEMETERY	23d. LOCATION CITY OR TOWN BALTIMORE	23e. COUNTY MARYLAND					
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MD 21215	25a. DATE REC'D. BY REGISTRAR AUG 25 1987	25b. REGISTRAR'S SIGNATURE <i>John Deacon-Landale</i>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please execute it as soon as possible.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it may be filed in the funeral director's office. Then please renew the permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other unusual condition, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										23308				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)		WENDELL G. BAXTER SR.			LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
(BAXTER)		WENDELL					8 16 87					9:46		
3. SEX		MALE			4. RACE		BLACK		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
					WHITE				MONTH 8 DAY 3 YEAR 23		64 yr. yrs.		IF UNDER 24 YEARS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		MD			7b. CITIZEN OF WHAT COUNTRY?		U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH		BALTIMORE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		ODDS SAMARITAN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		Disabled N/A	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		6812 STURBRIDGE DR. 21234		
14. FATHER'S NAME		FIRST Wm.	MIDDLE E.	LAST Baxter	15. MOTHER'S MAIDEN NAME		Hannah	16. INFORMANT		ADDRESS		Hueitt		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		yes Army 217206847 few seconds		17. INFORMANT		ADDRESS		Ethel E. Baxter 6812 Sturbridge DR		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARDIAC ARREST.														
DUE TO, OR AS A CONSEQUENCE OF (b) ISCHEMIC CARDIOMYOPATHY.														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 8/16/87 to 8/16/87, that (I) (we) last saw the deceased alive on 8/16/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.														
22b. SIGNATURE		Bliss			MD.			DEGREE		22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		BASSAM ATIYEH.			ATTENDING PHYSICIAN <input type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		8/16/1987		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE			
BURIAL		8/21/87		SUSQUEHANNA MEM. GDN.			DALLASTOWN,				PA			
24. FUNERAL DIRECTOR NAME		WM. C. MARCH F/H, INC.			ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
		1101 E. NORTH AVE.					AUG 20 1987		Julia Gordon-Lindalee					

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

23309

REG. NO.

1. DECEASED-NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED				MONTH	DAY	YEAR	2b. HOUR
LILLIAN			WERTHAN			<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8	4	1987		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	8. IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD				MONTH	DAY	YEAR	2d. HOUR
Female	White	Oct 10, 1917	69 yrs			<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8	4	1987	1:20 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH				
Lancaster, Pa.		U.S.A.							Baltimore City				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore		University Hospital (STU)			Homemaker				99999				
13a. STATE Pa.		13b. COUNTY Lancaster		13c. CITY OR TOWN Lancaster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 401 Eden Road, Apt W-					
FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME Edna		MIDDLE		LAST			
Moses				Lacarowitz						Zimmerman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS							
No		172-05-4038		Norbert Wertham		Pa. 17601				401 Eden Rd Lancaster,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries with complications</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
8121 Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>													
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c) DUE TO, OR AS A CONSEQUENCE OF													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
										<input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET Northbound I-95 & Rt. 166		CITY OR TOWN		CITY OR TOWN		COUNTY		STATE	
						Baltimore						MD	
22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		TITLE (SPECIFY) <u>Deputy Chief</u> M.D. MEDICAL EXAMINER										DATE SIGNED <u>8-4-87</u>	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS <u>111 Penn St., Balto., MD 21201</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		CITY OR TOWN		COUNTY		STATE	
Burial		Aug 5, 1987		Degel Israel Cemetery		Lancaster		Lancaster		Pa.			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Eline Funeral Home		Reisterstown, Md. 21136		AUG 10 1987		<u>L. Johnson-Pandrea</u>							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 and 4 should be detached for use as the burial/transit permit. Then pin removed, carbon paper, page 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.					
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR					
DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	AUGUST 12, 1987							7:44 A.M.		
MATTHEW DAVID WEST															
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR January 31 1976			6. AGE (IN YEARS LAST BIRTHDAY) 11 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY		MD.						
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) student			12b. KIND OF BUSINESS OR INDUSTRY								
13a. STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1334 Leeds Road		21921				
14. FATHER'S NAME FIRST Timothy		MIDDLE C.		LAST West			15. MOTHER'S MAIDEN NAME FIRST Rebecca		MIDDLE		LAST Slater				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. none		17. INFORMANT			ADDRESS								
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cardiac Arrest		DUE TO, OR AS A CONSEQUENCE OF Multi Organ Failure			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min								
{ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Cardiac Arrest		{ DUE TO, OR AS A CONSEQUENCE OF Multi Organ Failure			8 days								
{		{		{ DUE TO, OR AS A CONSEQUENCE OF Acute Myelogenous Leukemia			7 mos								
{		{		{ Acute Myelogenous Leukemia											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Graft Versus Host Disease															
19a. DATE OF OPERATION 8-5-87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Open lung biopsy		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8/4/87 to 8/21, 1987, that (I) (we) last saw the deceased alive on 8/12, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Gary A. Johnson		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22d. DATE SIGNED 8-17-87									
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Gary A. Johnson		22f. ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 08/17/87		23c. NAME OF CEMETERY OR CREMATORIAL Head of Christiana		23d. LOCATION CITY OR TOWN Newark		COUNTY		STATE New Castle Delaware					
24. FUNERAL DIRECTOR NAME <i>James T. Ondrej</i> ADDRESS <i>2506 Concord Pike</i> Chandler Funeral Home Wilm., DE 19803		25a. DATE REC'D. BY REGISTRAR AUG 19 1987		25b. REGISTRAR'S SIGNATURE <i>James T. Ondrej</i>											

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062722 AUG

FOR
SALE
REGISTRAR
1487

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

23311
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR	
Guy Thomas Wetzel						<input checked="" type="checkbox"/>	8	11	1987	M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN	8. IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
Male	White	April 3, 1912	75 yrs			<input checked="" type="checkbox"/>	8	11	1987	A.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		USA					Baltimore City				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		Union Memorial Hospital			Cement Mason			Steel			
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS		McMechen St., Balto. Md. 21217			
Maryland		Hancock	Baltimore			Apt. 1025 Memorial Apts. 301					
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST				
Clinton		(nmn)	Wetzel	Lucy		(nmn)	Rowe				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) 16b. SOCIAL SECURITY NO.		16c. ADDRESS		17. INFORMANT		Abingdon, Md. 21009					
No		--		Barbara A. Rovine, 2910 Strathaven Lane							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
					<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Mario F. Golle Jr.</i>											
TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 8/12/87											
EXAMINER'S NAME (TYPE OR PRINT)		Mario F. Golle, Jr., M.D.			ADDRESS 111 Penn St. Balto. MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE
Cremation		Aug. 15, 1987		R.A. Ferris Crematory			W. Chester		Chester		Pa.
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REG'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Howard K. McComas III, Abingdon, Md. 21009					AUG 13 1987		Howard K. McComas III, Abingdon, Md. 21009				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then bury or cremate the carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner/must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										23312	
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							REG. NO.	
1c DECEDED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	8 20 1987			2b HOUR		
FRANK J. WHEELER											
3 SEX male		4 RACE black		5. DATE OF BIRTH MONTH 8 DAY 24 YEAR 17			6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va,		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore city		MD.		
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT AN SUCH FACILITY, GIVE STREET ADDRESS) 100 N. Dennis St.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steel Mill			12b. KIND OF BUSINESS OR INDUSTRY Beth Steel				
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 100 N. Dennis St 21229		
14. FATHER'S NAME FIRST Ben		MIDDLE Wheeler		15. MOTHER'S MAIDEN NAME FIRST Eva			MIDDLE Mae		LAST Luby		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII		17. INFORMANT Virginia Wheeler			ADDRESS 100 N. Denison St				
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) LUNG CANCER - METASTATIC											
DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 4/15/87 to 8/20/87, that (I) (we) last saw the deceased alive on 8/6/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Dana H. Frank</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/20/87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANA H. FRANK		22e. ADDRESS 611 Park Ave Balt. Md. 21201									
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE 8/24/87		23c. NAME OF CEMETERY OR CREMATORIAL Garrison Forest Vet			23d. LOCATION CITY OR TOWN Owings Mills, Md.				
24. FUNERAL DIRECTOR NAME Wm. C. March F/H West		ADDRESS 4300 Wabash Avenue		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				

WAS ON 608600

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial/transit permit. Then please remove carbon from page 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma:

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23313	
1 - STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR			
ADA		F.	Whitcomb		8	19	87		2-36	AM			
3. SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		MONTH 10	DAY 4	YEAR 1904	82	YRS.	MONTHS	DAYS	HOURS	MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.					
Owings Mills		U.S.A.				Balto. City							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY							
Balto. City		Liberty Med. Center		Housewife									
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE							
MD		Carroll	Hamstead			801 Clearview Ave 21074							
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST						
Jacob			Turnbaugh	Annie			Wessel						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No		219-42-5011		Robert . Whitcomb		801 Clearview Ave. 21074							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio respiratory arrest</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
912 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>aspiration</u> (c) <u>Sepsis</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>infected decubitus ulcers, Diabetes Mellitus</u>													
19a. DATE OF OPERATION 7/30/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED extensive decubitus ulcers		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7/20/87 to 8/19/87, that (I) (we) last saw the deceased alive on 8/19/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, check here) <input type="checkbox"/>													
22b. SIGNATURE Z.N. Larrys		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 8/19/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Z.N. LARRY		22e. ADDRESS Liberty Medical Center											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/19/87		23c. NAME OF CEMETERY OR CREMATORIAL Evergreen Memorial		23d. LOCATION CITY OR TOWN Finksburg		COUNTY Carroll	STATE Md.				
24. FUNERAL DIRECTOR NAME Eline Funeral Home		ADDRESS Reisterstown, Md. 21136		25a. DATE REC'D. BY REGISTRAR AUG 24 1987		25b. REGISTRAR'S SIGNATURE							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requiring this certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, please return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical certification is required.

2

064149 AUG 31 1987

MEDICAL CERTIFICATION

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH23314
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST BABY	MIDDLE GIRL	LAST WHITE	2a. DATE OF DEATH MONTH AUGUST 22, 1987	DAY YEAR 2b. HOUR A 12:30 M		
3. SEX FEMALE		4. RACE BLACK	5. DATE OF BIRTH 08/22/1987		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. MONTHS 0	IF UNDER 24 HRS. HOURS 30		
7a. BIRTHPLACE BALTIMORE		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SAME FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 638 GUTMAN AVE 21218			
14. FATHER'S NAME NATHAN		MIDDLE STOKES	15. MOTHER'S MAIDEN NAME JEAN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT JEAN WHITE		ADDRESS ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CARDIO PULMONARY FAILURE							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Hour
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (b) PREMATURITY							
		DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/22</u> , 19 <u>87</u> , to <u>8/22</u> , 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>8/22</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									22c. DATE SIGNED <u>8/22/87</u>
22b. SIGNATURE <u>JANET N. SCHEEL, MD</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JANET N. SCHEEL, MD</u>		22e. ADDRESS 600 N. WOLFE ST. BALTIMORE, MD 21205							
23a. BURIAL, CREMATION, REMOVAL CREMATION		23b. DATE 08/22/87		23c. NAME OF CEMETERY OR CREMATORIAL JHH		23d. LOCATION CITY OR TOWN BALTIMORE, MD		COUNTY STATE	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR AUG 28 1987		25b. REGISTRAR'S SIGNATURE <u>J. Harlan Johnson, Jr.</u>			

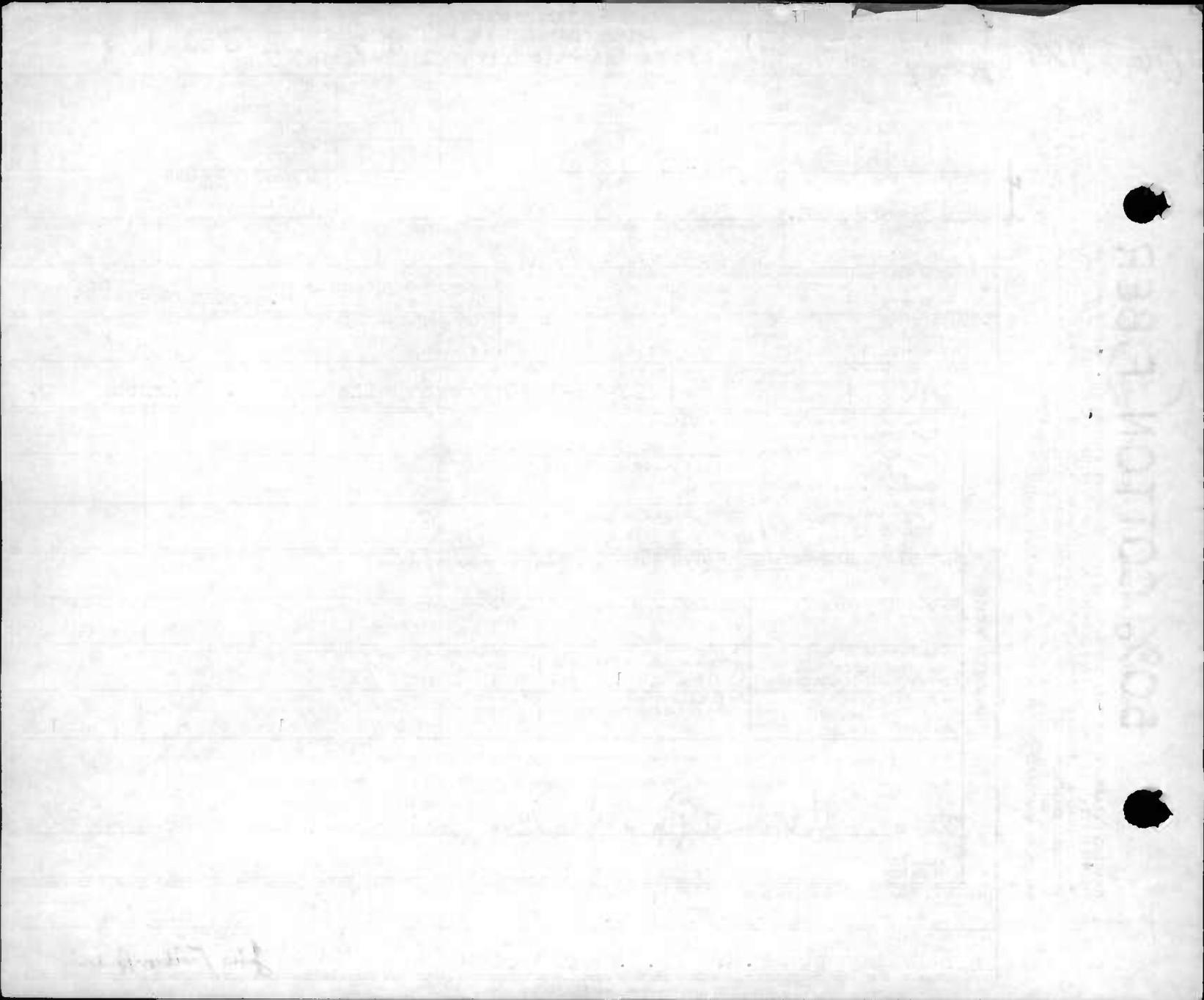
10 16 2011 PA 1420

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM BM-3 RETAIN PAGES 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH						REG. NO. 23315					
FOR 1. STATE 2. CITY OR TOWN 3. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH ESTI- MATED	MONTH MONTH	DAY DAY	YEAR YEAR	2b. HOUR 2d HOUR			
GREGORY WHITE						8-10-87 19			M		
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 04-30-57	6. AGE (IN YEARS LAST BIRTHDAY) 30 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD 8-10-87 19			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.	7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED				10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 309 N. Warwick Avenue	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labora	12b. KIND OF BUSINESS OR INDUSTRY 21223
13a. STATE Maryland	13b. COUNTY	13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 2717 W. Fairmont Ave.					
14. FATHER'S NAME FIRST David	MIDDLE White	LAST	15. MOTHER'S MAIDEN NAME FIRST Laura			MIDDLE Davis	LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No	16b. SOCIAL SECURITY NO. 217-68-3044			17. INFORMANT Laura White	ADDRESS 2717 W. Fairmont Ave.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute narcotic intoxication DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (e).											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR Primary CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9:00 P.M. 8 10 19 87			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject used drugs							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) truck cab			21f. LOCATION STREET 309 N. Warwick Avenue, Baltimore,			CITY OR TOWN	COUNTY	STATE Maryland		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/> .									TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER		
									DATE 8-10-87 SIGNED		
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 08-15-87	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Calvary Cemetery			23d. LOCATION CITY OR TOWN Baltimore, Maryland	25a. COUNTY	25b. STATE				
24. FUNERAL DIRECTOR NAME Brown/Thompson F.H.	ADDRESS P.O. Box 4433										
25a. DATE REC'D. BY REGISTRAR AUG 14 1987									25b. REGISTRAR'S SIGNATURE Julia Gordon Randall		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										23316					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE		LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
HATTIE J. WHITE										8 20 1987				M	
3. SEX FEMALE		4. RACE BLACK			5. DATE OF BIRTH MONTH 02 DAY 14 YEAR 1899		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY							
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HAYS CARE NURSING HOME			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED			12b. KIND OF BUSINESS OR INDUSTRY DOMESTIC							
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2913 W. LANVALE STREET 21216			MD.				
14. FATHER'S NAME EDWARD		15. MOTHER'S MAIDEN NAME SOPHINA			16. SOCIAL SECURITY NO. NO 217-22-9891		17. INFORMANT SADIE GWALTNEY			ADDRESS BALTIMORE, MARYLAND 1933 FULTON AVENUE 21217					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UTERINE CANCER										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)															
DUE TO, OR AS A CONSEQUENCE OF (c)															
DUE TO, OR AS A CONSEQUENCE OF															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED <input checked="" type="checkbox"/>			ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that (1) this hospital attended the deceased from 8/4 1987 to 8/19 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) we did not view the body after death.															
22b. SIGNATURE STEVEN A. SCHONFELD, M.D.										DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22c. DATE SIGNED 8/26/87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEVEN A. SCHONFELD			22e. ADDRESS SINAI HOSPITAL BALTIMORE 21215										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE BURIAL 8/26/1987			23c. NAME OF CEMETERY OR CREMATORIAL WOODLAWN CEMETERY			23d. LOCATION CITY OR TOWN			23e. COUNTY BALTIMORE, MARYLAND				
24. FUNERAL DIRECTOR NAME NUNER FUNERAL HOMES, INC.		ADDRESS 2501 GWYNNS FALLS PKWY. BALTIMORE, MD. 21216			25a. DATE REC'D. BY REGISTRAR AUG 27 1987			25b. REGISTRAR'S SIGNATURE Julia Darden-Randall							

00414 VAC 101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours of death. Page 4 may be rehanded by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed, it should be detached for use as the burial/transit permit. Then please remit one copy to the State Dept. of Health and Mental Hygiene prior to burial or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 13 can phone
FOR
1 - STATE
REGISTRAR
9/4/87 DRD
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

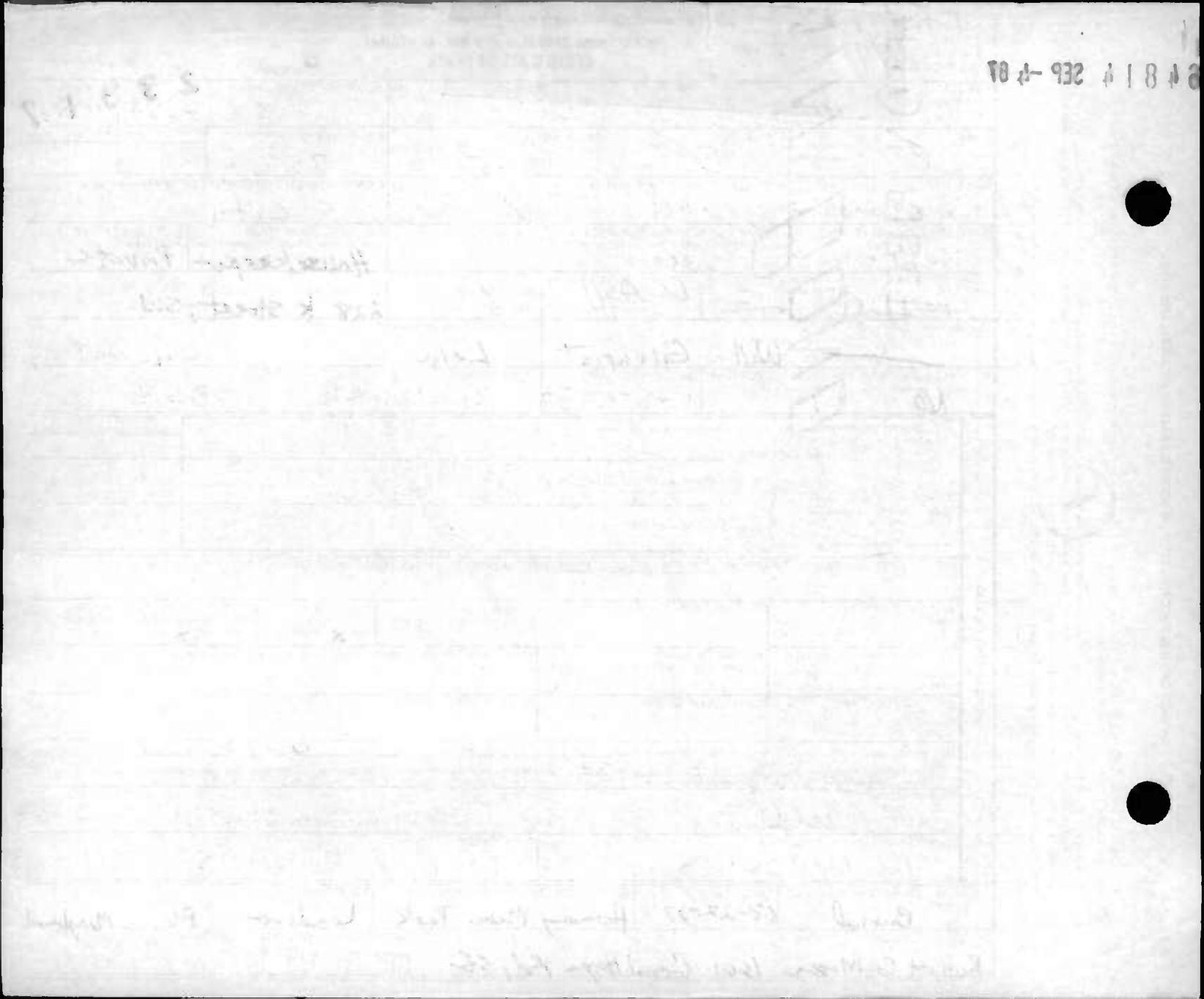
REG. NO.

2 3 3 3 HOUR
8 - 17 - 87 4:00 AM

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	2b. REG. NO.
<u>Lucille</u>					<u>White</u>	8 - 17 - 87	3	2 3 3 3 HOUR 4:00 AM
3. SEX		4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		7. IF UNDER 24 HRS.
<u>F</u>		<u>B</u>	MONTH	DAY	YEAR	MONTHS	DAYS	MONTHS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
<u>S. Carolina</u>		<u>USA</u>				<u>City</u>		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
<u>Baltimore</u>		<u>SBGH</u>				<u>Housekeeper</u>		<u>Private</u>
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE
<u>MD</u>		<u>Baltimore</u>		<u>Baltimore</u>				<u>228 K street, SW 20009</u>
14. FATHER'S NAME		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME				
<u>John Will</u>			<u>Gilchrist</u>	<u>Lela</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
<u>NO</u>		<u>578-109507</u>		<u>R. Wudrick</u>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>sepsis</u>								
DUE TO, OR AS A CONSEQUENCE OF (b) <u>social decubitus</u>								
DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>7-17-87</u> , 19 <u>87</u> , to <u>8-17</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>8-17</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.								
22b. SIGNATURE <u>R. Wudrick</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>8-17-87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>R. Wudrick</u>		22e. ADDRESS <u>3001 S. Hanover St. Balt. MD</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>08-22-87</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Harmony Mem. Park</u>		23d. LOCATION CITY OR TOWN <u>Landon</u>		COUNTY <u>PG</u>
24. FUNERAL DIRECTOR NAME <u>Robert Co. Moser</u>		ADDRESS <u>1661 Good Hope Rd, SE</u>		25a. DATE REC'D. BY REGISTRAR <u>SEP 3 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Scidmore-Landau</u>		

BP _____
9999999
DHMH 16:00M 7/84
(VRA 15, 4)

104-932 41842



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please remove carbon papers. Pages 1 and 2 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified prior to burial.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										23018				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2d HOUR		
Mary C. White						August 11, 1987						5:30 PM		
3. SEX			4. RACE		5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE IN YEARS (LAST BIRTHDAY)			
Female			White		April 14, 1929						IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland			USA								Baltimore City			
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore			Francis Scott Key Medical Center			Cashier			Super Super					
13a STATE			13b COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
Maryland			Baltimore		Dundalk					8628 Sandy Plains Road 21222				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST			
Joseph					Padula	Helen					Rossi			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS					
No			220-24-6540			Wayne L. White			8628 Sandy Plains Rd. 21222					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>transstentorial herniation</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10'</u>				
DUE TO, OR AS A CONSEQUENCE OF (b) <u>sub arachnoid hemorrhage</u>										<u>24'</u>				
DUE TO, OR AS A CONSEQUENCE OF (c) _____														
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)														
MEDICAL CERTIFICATION			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on _____, 19_____. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>Richard Lewis</u>			MO			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>8/11/87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Richard Lewis</u>			22e. ADDRESS <u>FSK Hosp, Eastern Ave, Balt</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-15-87			23c. NAME OF CEMETERY OR CREMATORIAL Sacred Heart of Jesus			23d. LOCATION CITY OR TOWN Baltimore Maryland					
24. FUNERAL DIRECTOR NAME			Duda-Ruck Funeral Home of Dundalk ADDRESS 7922 Wise Ave. Dundalk, MD 21222			25a. DATE REC'D. BY REGISTRAR <u>AUG 14 1987</u>			25b. REGISTRAR'S SIGNATURE					

085032 001503

autumnal transition
and seasonal changes.

relative abundance on land
the most abundant species was *Carduus*.

062701 AUG 14 87

23319

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

Nannie L. White

2a DATE OF DEATH MONTH DAY YEAR 2b HOUR
8-9-87 4:05 AM

3. SEX

FEMALE

4. RACE

BLACK

5. DATE OF BIRTH

MONTH 5 DAY 6 YEAR 08

6. AGE (IN YEARS LAST BIRTHDAY)

IF UNDER 1 YEAR
MONTHS 79 YRS.
DAYS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Virginia

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED NEVER MARRIED
WIDOWED DIVORCED

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE city MD.

10. CITY OR TOWN OF DEATH

BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

BON SECOURS HOSPITAL

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)

Retiree

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

Md

13b. COUNTY

Baltimore

13d. INSIDE CITY LIMITS?

YES NO

13e. STREET ADDRESS / ZIP CODE

21215

4002 Edgewood Road

14. FATHER'S NAME

Robert

MIDDLE

Grant

15. MOTHER'S MAIDEN NAME

Nancy

A.

Smith

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

219-22-3135A

17. INFORMANT

(NAME AND ADDRESS)

Willie Johnson 2137 Koko Lane

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Ac. Hemorrhagic Pancreatitis

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b)

Recurrent PULM. Thrombo-emboli; Rel

DUE TO, OR AS A CONSEQUENCE OF Post of left FEMORAL TO DISTAL
(c) ARTERIO-BYPASS GRAFT

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Arterio Scrorosis

19a. DATE OF OPERATION

7/29/87

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

OCCURRING OVER 60% TO 70% FEMORAL GANGRENE

20a. AUTOPSY?

YES NO 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES NO

21a. ACCIDENT WAS UNDERLYING

OR CONTRIBUTING CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED

(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK NOT WHILE AT WORK

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from

saw the deceased alive on

above (I) (we) did (did not) view the body after death

22b. SIGNATURE

22c. DEGREE

ATTENDING PHYSICIAN MEDICAL DIRECTOR STAFF PHYSICIAN

22d. DATE SIGNED

8/12/87

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

8/13/87

23c. NAME OF CEMETERY OR CREMATORIUM

King MEMORIAL Park

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

Randallstown

Md

BP _____

DHMH - 16 60M 7/84

(VRA 15, 4)

24. FUNERAL DIRECTOR

NAME

Wm. C. March F/H West

4300 Wabash Avenue

ADDRESS

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

AUG 13 1987 Julia Sanderson

065101 VUE 188

TM 51 00

062662 AUG

1387
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

23320

REG. NO.

B
 TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 2 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI. DEATH MATED	MONTH	DAY	YEAR	2b. HOUR	
ROOSEVELT JASPER WHITE						<input checked="" type="checkbox"/>					
SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
MALE	BLACK	12 5 36	50 YRS.	MONTHS	DAYS	HOURS	MIN				
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED		NEVER MARRIED		DIVORCED		
MD		BALTO.			<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
Baltimore		1405 Holbrook Street					DISABLED				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			12b. KIND OF BUSINESS OR INDUSTRY
MD				BALTO.		<input checked="" type="checkbox"/> YES		1405 HOLBROOK STREET 21202			N/A
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		ADDRESS			LAST
THEODUS				WHITE		VIOLA		TONYA WHITE 43 STRAWHAT RD APT 3A			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <input checked="" type="checkbox"/> YES		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
		217-30-2881				Cirrhosis of liver					
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause lost.</u>		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?					
						<input checked="" type="checkbox"/> YES		<input type="checkbox"/> NO			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: <input checked="" type="checkbox"/> Natural causes, <input type="checkbox"/> Accident, <input type="checkbox"/> Suicide, <input type="checkbox"/> Homicide, <input type="checkbox"/> Undetermined manner		Autopsy <input checked="" type="checkbox"/>		Inspection <input type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion			
ACTUAL SIGNATURE		Margarita A. Korell, M.D.		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED			
EXAMINER'S NAME (TYPE OR PRINT)								8-6-87			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE BURIAL 8/13/87		23c. NAME OF CEMETERY OR CREMATORIUM GARRISON FOREST CEM.		23d. LOCATION CITY OR TOWN OWINGS MILLS		COUNTY		STATE MD	
24. FUNERAL DIRECTOR WM. C. MARCH F/H 1101 E. NORTH AVENUE						25a. DATE REC'D. BY REGISTRAR AUG 12 1987		25b. REGISTRAR'S SIGNATURE Julia Dandrea-Lundeen			

082665 MA 1391



81 300

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, medical examiner must be notified once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87 2332			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR	
ISAAC					WHITEHEAD	AUGUST 28, 1987						7:35 P.M.	
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE [IN YEARS LAST BIRTHDAY]			IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE			BLACK		MONTH DAY YEAR 10 05 1899		87			MONTHS	YEARS	HOURS	MIN.
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			BALTIMORE CITY			
N. CAROLINA			U. S. A.				BALTIMORE CITY						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS INDUSTRY				
BALTIMORE CITY			MARYLAND GENERAL HOSPITAL			CONTRACTOR			WHITE+TURNER				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
MARYLAND					BALTIMORE		NO			1701 EUTAW PLACE APT. 807			
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			MIDDLE	LAST			
ISAAC					WHITEHEAD	CORA				UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
NO,			213-09-3617A			MRS. ELIZABETH WHITEHEAD			BALTIMORE, MD, 21217				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). (c)													
DUE TO, OR AS A CONSEQUENCE OF													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) PROSTATIC CARCINOMA WITH BONE METASTASIS													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from AUGUST 25, 1987, to AUGUST 28, 1987, that (we) last saw the deceased alive on AUGUST 28, 1987, and that (I) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) <input checked="" type="checkbox"/> view the body after death.													
27a. SIGNATURE <i>H. Ghandour</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Hassan Ghandour</i>			22e. ADDRESS			c/o MARYLAND GENERAL HOSPITAL							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 9/03/1987			23c. NAME OF CEMETERY OR CREMATORIAL CEDAR HILL CEMETERY			23d. LOCATION CITY OR TOWN			BALTO, MARYLAND	
24. FUNERAL DIRECTOR NAME NUTTER FUNERAL HOMES, INC. ADDRESS 2501 GWYNN'S FALLS PKWY. BALTO, MD, 21216			25a. DATE REC'D. BY REGISTRAR SEP 03 1987			25b. REGISTRAR'S SIGNATURE <i>Julie Leider-Randall</i>							

104-932-087400

to the Board of Directors

SEP 02 1988 10:00 AM 1988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 7 23322
1 - FOR STATE REGISTRAR		1a. DECEASED NAME (TYPE OR PRINT) ALMA WHITTINGTON			2a. DATE OF DEATH MONTH DAY YEAR 8 27 87
		FIRST	MIDDLE	LAST	2b. HOUR M
3. SEX FEMALE		4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 8 9 11	6. AGE (IN YEARS LAST BIRTHDAY) 76	IF UNDER 1 YEAR MONTHS DAYS YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY	10. IF UNDER 24 HRS HOURS MIN. MD.
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2617 BERYL AVENUE			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A
13a. STATE MD		13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS, ZIP CODE 2617 BERYL AVENUE 21205
14. FATHER'S NAME FIRST BEVERLY		MIDDLE ROY	LAST HELEN	15. MOTHER'S MAIDEN NAME FIRST GILMORE	MIDDLE LAST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220-07-0940	17. INFORMANT JEAN J. SCOTT 2617 BERYL AVENUE	ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 MINS					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 ISCHEMIC HEART DISEASE					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) BY SCOTT CARNIVALE MD			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 7/1/87 , 19 87 , to 8/1/87 , 19 87 , that (we) last saw the deceased alive on 5/1/87 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE SCOTT CARNIVALE		DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 8/31/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SCOTT CARNIVALE		22e. ADDRESS JOHNS HOPKINS HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 9/2/87	23c. NAME OF CEMETERY OR CREMATORIAL CEDAR HILL CEMETERY	23d. LOCATION CITY OR TOWN ANNE ARUNDEL CO.	COUNTY	STATE MD
24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H. INC.		ADDRESS 1101 E. NORTH AVE.	25a. DATE REC'D. BY REGISTRAR SEP 1 1987	25b. REGISTRAR'S SIGNATURE Julie Sanders-Randall	

064803 SEC-581

15271

063732 AUG 26 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23325

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	21b. HOUR					
<i>Phyllis CAROLYN WILBURN</i>						08	23	87		1325 M					
3. SEX			4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR						
<i>FEMALE</i>			<i>CAUCASIAN</i>	MONTH	DAY	YEAR	53		MONTHS	IF UNDER 24 HRS					
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.					
<i>W. VIRGINIA</i>			<i>USA</i>				<i>BALTIMORE CITY</i>								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
<i>BALTO. CITY</i>			<i>ST AGNES HOSPITAL</i>						<i>SELF-EMPLOYED</i>			<i>MD.</i>			
13a. STATE			13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			2. 1230			
<i>MD</i>				<i>BALTIMORE</i>					<i>1927 CASADEL AVE</i>						
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST	FUGET			
<i>Lorraine</i>					<i>Lily</i>	<i>Doris</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			16c. INFORMANT			16d. ADDRESS			1957 CASADEL AVE.			
<i>NO</i>			<i>234-52-0447</i>			<i>JAMES E WILBURN</i>			<i>BALTO MD 21230</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ventricular Arrhythmia, - VT, VF, Asystole</i> 30 min														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Precipitated Myocardial Infarction</i>															
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Congestive Heart Failure</i>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
								<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)										
		P.M. 19													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>8/23</i> , 19 <i>87</i> , to <i>8/23</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>8/23</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>J. Curran</i> DEGREE															
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> 22c. DATE SIGNED <i>8/23/87</i>															
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS													
<i>Soo Gil Lee MD.</i>		<i>St. Agnes Hosp</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMAORY			23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE				
<i>ENTOMBMENT</i>		<i>8-27-87</i>		<i>HOLLY HILLS</i>			<i>BALTIMORE</i>				<i>MD</i>				
24. FUNERAL DIRECTOR NAME		ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
<i>McCULLY FUNERAL HOME</i>		<i>237 E. PATAPSCO</i>						<i>25 AUG 25 1987</i>		<i>Julie Diagonal-Purcell</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper. If you have any questions concerning this form, contact the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

06343 VHS 3261

the first time I have seen it. It is a very
large tree, about 100' tall,
and about 10' in diameter at the base.
The bark is smooth and grey,
but has some horizontal ridges.
The leaves are large and
widely spaced along the branches.
The flowers are white and
fragrant, appearing in clusters.
The fruit is a small, round, yellowish
berry, about the size of a pea.
The tree is found in the
mountainous regions of the western
United States, particularly in California
and Oregon. It is a very
valuable timber tree, and is
used for construction, furniture,
and other purposes. It is also
used for its timber, which is
very strong and durable.
The wood is used for
construction, furniture,
and other purposes. It is also
used for its timber, which is
very strong and durable.

064141 AUG 3 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23324

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	26. HOUR			
			Wilma	S.	Wiles	08	25	87	10:00	P M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		MONTH	DAY	YEAR	56	YRS	MONTHS	DAYS	HOURS	MIN.	
11. CITY OR TOWN OF DEATH		12. CITIZEN OF WHAT COUNTRY?		13. DATE OF BIRTH		14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		15. FATHER'S NAME		16. MOTHER'S MAIDEN NAME			
Baltimore		USA		MONTH	DAY	YEAR	MARYLAND	COUNTY	CITY OR TOWN	FIRST	MIDDLE	LAST	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)		17b. SOCIAL SECURITY NO.		17c. INSIDE CITY LIMITS?		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____		19. DATE OF OPERATION		20. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
No		220-74-1573		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Adenocarcinoma - metastatic						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 _____, to _____, 19 _____, that (I) (we) last saw the deceased alive on _____, 19 _____. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Betty A. Fay</i>													
22c. DEGREE													
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)													
22e. ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE			
Cremation		8/27/87		Green Mount Cemetery		Baltimore		Maryland					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
A. Alan Seitz, Jr. 3818 Roland Ave. 21211				AUG 28 1987		<i>Julia Sanderson-Lindner</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon copy of page 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of remains.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

10 16 2011 11:11 AM

marking

062428 AUG 2187

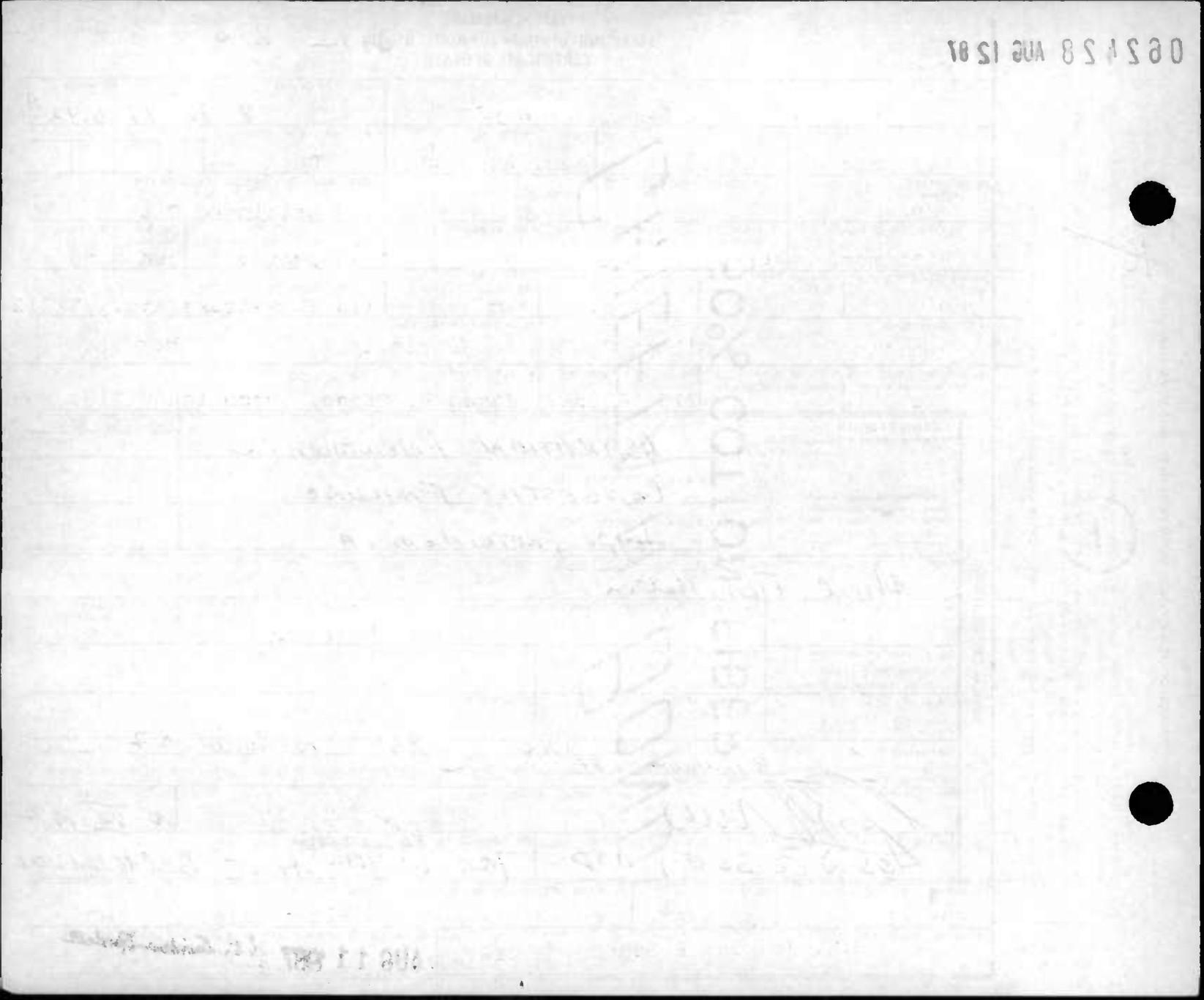
FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

23325

I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR		
FLORENCE			G.		WILHIDE	8	10	87	6:42 A.M.			
3. SEX	4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female	White			MONTH	DAY	YEAR	86	YRS	MONTHS	DAYS	IF UNDER 24 HRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MD		USA			WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore City			MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore		Keswick Home			Homemaker.			Own Home				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
MD				Balto.				114 E. Melrose Ave., 21212				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
Philip				Gibson	Henrietta		Morgan					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS					
No		219 36 0517			James D. Stone,		Brooklandville, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - ASPIRATION Pneumonia											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) - CONGESTIVE FAILURE												
DUE TO, OR AS A CONSEQUENCE OF (c) - HYPO PROTEINEMIA												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Atrial Fibrillation												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from Dec 19 85 to 10 August 1987, that <input type="checkbox"/> (we) last saw the deceased alive on 9 August 1987, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> did <input type="checkbox"/> did not view the body after death.											22c. DATE SIGNED 10 VIII 1987	
22b. SIGNATURE H.W. Jenkins		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22e. ADDRESS 700 W. 40th Street Baltimore MD												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/13/87		23c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge			23d. LOCATION CITY OR TOWN Pikesville, MD		23e. DATE REC'D. BY REGISTRAR AUG 11 1987			
24 FUNERAL DIRECTOR NAME H.W. Jenkins & Sons Co.		24b. ADDRESS 21212			24c. SIGNATURE H.W. Jenkins & Sons Co.			24d. DATE REC'D. BY REGISTRAR AUG 11 1987				

085458 Aug 15 81



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 23320				
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>George Wilkerson</i>									<i>8-4-87</i>				<i>10:45 AM</i>	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
<i>Male</i>		<i>Black</i>		<i>11 14 88</i>			<i>79</i>			<i>YRS.</i>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
<i>Virginia</i>		<i>USA</i>					<i>Baltimore City</i>							
10. CITY/TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
<i>Baltimore Md</i>		<i>Joseph Richey Hospice - Balt. 21201</i>												
13a. STATE <i>Md.</i>		13b. COUNTY		13c. CITY OR TOWN <i>Baltimore Md.</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <i>405 East 22nd St., Baltimore 21218</i>				
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST			LAST							
<i>Henry Wilkerson</i>				<i>Louise Overbee</i>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS							
<i>No</i>		<i>210-10-7230</i>		<i>George W. Keasen, R.N. Richey Hospice</i>			<i>as above</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
IMMEDIATE CAUSE (a)		<i>Respiratory Arrest</i> minutes												
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastasis - Lung.</i>		4 mos												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Carcinoma of Prostate</i>		13 mos.												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
					YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>8-4</i> to <i>8-4</i> , 19 <i>87</i> , to <i>8-4</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>8-4</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.														
22b. SIGNATURE <i>Robert C. Irwin MD</i>		DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>8-4-87</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert C. Irwin MD</i>		22e. ADDRESS <i>828 N. Eutaw St. Balt. Md. 21201</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>8-8-87</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>ARBUTUS Mem. Pk.</i>			23d. LOCATION CITY/TOWN <i>Balt. Md.</i>							
24. FUNERAL DIRECTOR NAME <i>Calvin B. Scruggs</i>		ADDRESS <i>14102 E. Preston St.</i>		25a. DATE REC'D. BY REGISTRAR <i>AUG 5 1987</i>			25b. REGISTRAR'S SIGNATURE <i>Julia Deidra Landree</i>							

061828 VUE-201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon copy and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic condition, notify medical examiner must be notified at once.

MEDICAL CERTIFICATION

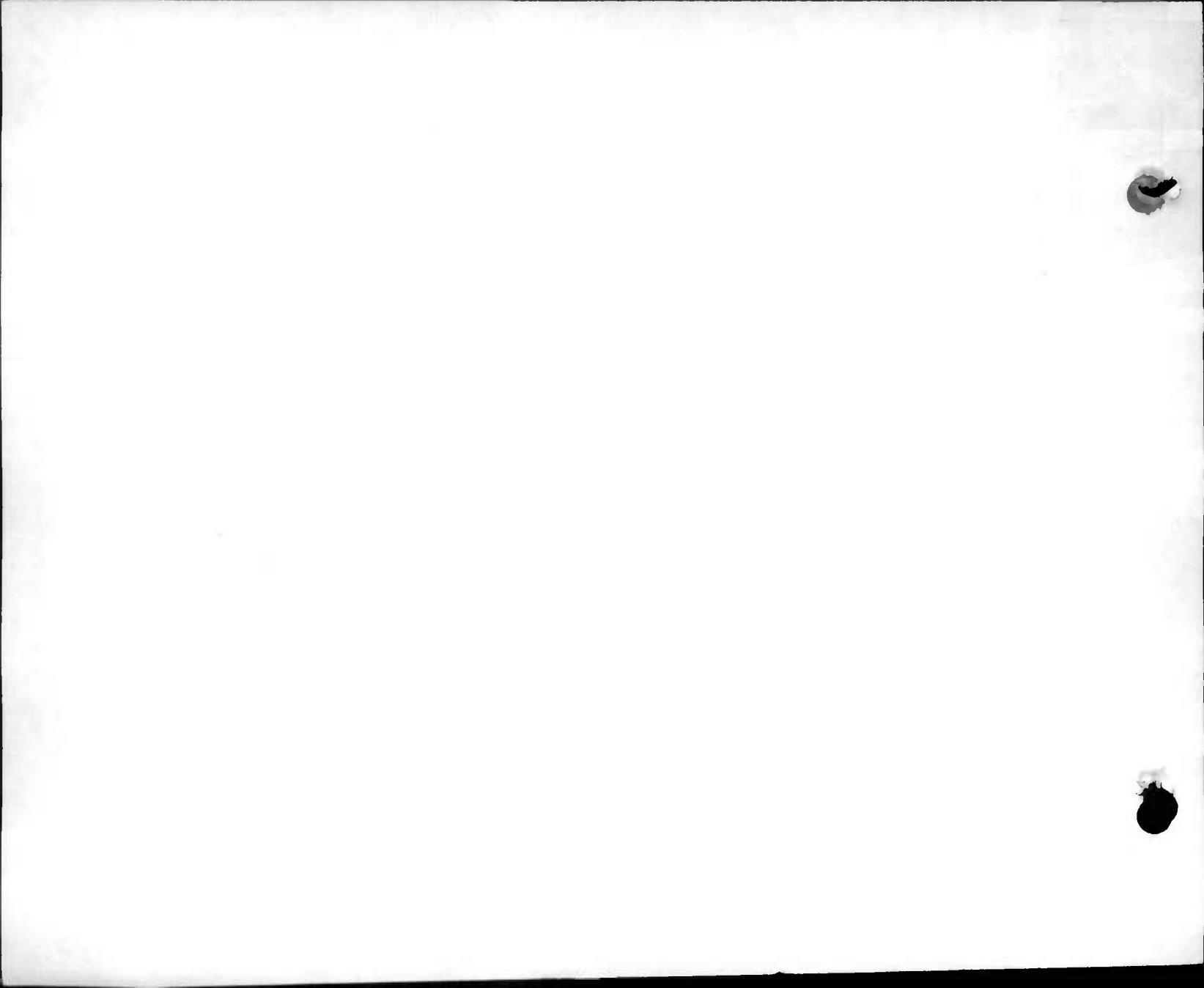
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 23327			
1. DECEASED NAME (TYPE OR PRINT)		FIRST Garnett Wilkins	MIDDLE	LAST	2a DATE OF DEATH MONTH DAY YEAR 8 20 87	2b HOUR 11:15 am	
3. SEX MALE		4. RACE BLACK	5. DATE OF BIRTH MONTH 7 DAY 16 YEAR 11		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS 76 YRS IF UNDER 24 HRS MONTHS 0 DAYS 0 HOURS 0 MIN. 0		
7a BIRTHPLACE COUNTRY SC		7b CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY N/A
13a. STATE MD		13b. COUNTY	13c. CITY OR TOWN BALTO.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 535 E. 38th STREET 21218	
14. FATHER'S NAME FIRST GEORGE		MIDDLE	LAST WILKINS	15. MOTHER'S MAIDEN NAME FIRST PEARL		MIDDLE	LAST McGERDY
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-07-3417		17. INFORMANT NOVELLA SMITH 633 N. AISQUITH STREET APT 7H		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Lung & Metastasis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) DUE TO, OR AS A CONSEQUENCE OF							
(c) DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) this hospital attended the deceased from July 31 , 19 87 , to Aug 20 , 19 87 , that (I) (we) last saw the deceased alive on Aug 20 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Bernie Nappal		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22d. DATE SIGNED 8-20-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. Nappal		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/24/87	23c. NAME OF CEMETERY OR CREMATORIAL EASTVIEW MEM. PK.		23d. LOCATION CITY OR TOWN DUNDALK,	COUNTY	STATE MD
24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H, INC.		ADDRESS 1101 E. NORTH AVE.	25a. DATE REC'D. BY REGISTRAR AUG 21 1987		25b. REGISTRAR'S SIGNATURE Julia Davison-Pandrea		

63281 100-2561

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Void Death Certificate #87-23328



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23329

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
<u>DANIEL BOY WILLIAMS</u>						<u>5 24 87</u>				<u>3 PM</u>		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
<u>MALE</u>		<u>BLACK</u>		<u>5 24 87</u>		<u>0</u>		<u>1</u>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
<u>MARYLAND</u>		<u>USA</u>				<u>BALTIMORE CITY</u>		<u>MD</u>				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
<u>BALTIMORE</u>		<u>SINAI HOSPITAL</u>		<u>6900</u>		<u>6900</u>						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
<u>MARYLAND</u>				<u>BALTIMORE</u>		<u>YES</u>		<u>2718 SETHLOW RD 21225</u>				
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		LAST				
						<u>KAREN</u>		<u>Williams</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						
<u>NO</u>												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>believe pneumonia</u>												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)												
DUE TO, OR AS A CONSEQUENCE OF												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>5/24</u> , 19 <u>87</u> , to <u>5/24</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>5/24</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Kathleen Stevens</u>		DEGREE <u>rn</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>8/27/87</u>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Kathleen Stevens</u>		22e. ADDRESS <u>Jesuit Hospital</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE		
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR <u>SEP 4 1987</u>		25b. REGISTRAR'S SIGNATURE <u>John F. Leon-Randall</u>						

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

23330

REG. NO.

1063405 AUG 21 1987
FOR Exam., 9/15/87, Gbj.
REGISTRAR

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 16. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR MONTH	DAY	YEAR	2d. HOUR
ANTHONY R. WILLIAMS							<input checked="" type="checkbox"/>	8-15-87	19					M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR.	IF UNDER 24 HRS.	MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR			
male	black	5 1 1958	29				<input checked="" type="checkbox"/>	8-15-87	19		1:32 AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH							
Md		U S A			<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		Baltimore City							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore				3101 Swann Drive (in auto)										
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS									
Md		Baltimore			245 N. Monastery 21229									
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Leroy Williams				Alice										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT			ADDRESS			
No				218-64-1459				Patricia Williams			2902 Oxford Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Narcotic intoxication DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?						
								<input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR Primary CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 8 15 19 87				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject used drugs						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) unknown				21f. LOCATION STREET CITY OR TOWN COUNTY STATE unknown						
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE <i>Mario F. Golle Jr.</i> M.D. Assistant MEDICAL EXAMINER												DATE SIGNED 8-15-87		
EXAMINER'S NAME (TYPE OR PRINT)				Mario F. Golle, Jr., M.D.				ADDRESS			111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY			STATE	
Burial				8/20/87		King Memorial Park		Randallstown					MD	
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Wm. C. March F/H West 4300				Wabash Avenue				AUG 20 1987			<i>Julia Linton-Lindner</i>			

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063470 AUG 24 87

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2333

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
<i>Derrick</i>					<i>Williams</i>	08	19	87	0510 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		
Male		Black		MONTH	DAY	YEAR	MONTHS	YEARS	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland		USA		08	01	87	0	0 17	MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY
Baltimore		St. Agnes Hospital				Infant				N/A
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		
Md.				Balto.				4811 Gwynn Oak Ave. 21207		
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		ADDRESS			
Larry Williams					Borendia Williams		Larry Williams 4811 Gwynn Oak Ave.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No		N/A		Larry Williams						
18. CAUSE OF DEATH (Enter only one cause per line for 18a, b, and c.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)						Bacterial Sepsis				
DUE TO, OR AS A CONSEQUENCE OF (b)										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Prematurity										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on		8/19/87		19		8/19/87	19			
above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR	STAFF PHYSICIAN	22c. DATED/SIGNED		
Carol A. Blank, MD							X	8/19/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS								
Carol A. Blank, MD		900 Caton Avenue, Baltimore, Md 21209								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. REGISTRAR'S SIGNATURE		
Burial		8/22/87		Garrison Forest		Owings Mill, Md				
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Leroy O. Dyett		4600 Liberty Heights		AUG 21 1987		Julia Bender				

1045 20A DT 1800

1045 20A DT 1800

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it may be filed with the funeral director. Page 3 should be detached for use as the burial/transit permit. Then place in envelope and mail to the State Dept. of Health and Mental Hygiene prior to burial.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other condition, the medical examiner must be notified at once.

1

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23332

REG. NO.

DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
DORA					WILLIAMS	AUGUST 19, 1987			6:25A M			
3. SEX	4. RACE	5. DATE OF BIRTH							6. AGE (IN YEARS LAST BIRTHDAY)			
Female	Black	MONTH 08 DAY 14 YEAR 87							IF UNDER 1 YEAR MONTHS DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8.							IF UNDER 24 HRS. HOURS MIN.			
Maryland	USA	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>							YRS.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						9. BALTIMORE CITY OR COUNTY OF DEATH					
BALTIMORE	THE JOHNS HOPKINS HOSPITAL						BALTIMORE CITY					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						13e. STREET ADDRESS / ZIP CODE			
Maryland		Baltimore							1713 Vine Street 21223			
14. FATHER'S NAME	FIRST	MIDDLE	FIRST	15. MOTHER'S MAIDEN NAME						MIDDLE	LAST	
William		Hopkins	Dora							Cooper		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						ADDRESS			
	212-24-8215	James William	RESPIRATORY ARREST						1713 Vine St.			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 minutes												
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.												
(b) CARCINOMATOSIS 15 days												
DUE TO, OR AS A CONSEQUENCE OF (c) CANCER 15 days												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
N/A	NA						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
		NA										
21d. INJURY OCCURRED <input type="checkbox"/> WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE							
22a. I certify that (I) (the hospital) attended the deceased from 8/14 saw the deceased alive on 8/19 1987, to 8/19 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) did (did not) view the body after death.	19. 87 to 19. 87, 19. 87, that (I) (we) last											
22b. SIGNATURE	DEGREE											
Thomas Steven M	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS											
Thomas Steven M	JOHNS HOPKINS HOSPITAL											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION CITY OR TOWN	22f. DATE SIGNED								
Burial	8-24-87	MT. Zion Cem	Baltimore, Maryland	8/19/87								
24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
Brown-Thompson F.H.	P.O. Box 44633	AUG 21 1987		Julia Gordon Pendleton								

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063266 VME 54 81

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23533

REG. NO.

1 - FOR
STATE
REGISTRAR

064603 SEP 28

DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
			JAMES	H.	WILLIAMS	AUGUST 27, 1987				2:15 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
male		black		MONTH 2 DAY 22 YEAR 1930		57		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled					
BALTIMORE		THE JOHNS HOPKINS HOSPITAL				12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 21223 1506 W. Fayette Street Apt 2			
Md				Baltimore							
14. FATHER'S NAME		FIRST MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		LAST			
		Jessie		Williams		Perce		Page			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No				239-38-2081		Delores Williams		6714 Chisholm Drive			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) BRAINSTROM COMPRESSION

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

5 days

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause, lost.

DUE TO, OR AS A CONSEQUENCE OF
INTRAURE CARCINOMA FROM LARYNX

Years

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Ischemic HEART DISEASE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
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21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
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22a. I certify that (I) (this hospital) attended the deceased from <u>24 AUGUST 1987</u> to <u>27 August 1987</u> , that (I) (we) last saw the deceased alive on <u>August 27 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <u>M. Shonton</u>	DEGREE MD	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>8/27/87</u>
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>M. Shonton</u>	22e. ADDRESS <u>Wabash Avenue</u>
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9/2/87	23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Cemetery	23d. LOCATION CITY OR TOWN Baltimore	COUNTY Md
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24 FUNERAL DIRECTOR NAME Wm. C. March F/H West 4300 Wabash Avenue	ADDRESS	25a. DATE REC'D. BY REGISTRAR AUG 31 1987	25b. REGISTRAR'S SIGNATURE <u>Julia Darden-Randall</u>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The lot 0271101169288
retained by the hospital or attending physician: 0271101169288
TO FUNERAL DIRECTOR: After this certificate has been signed, it should be detached for use as the burial-trust permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant condition contributing to death, attach a separate sheet.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please refer to "Burial Papers, Pages 1 and 2 should be filled with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial." (See page 1 and 2.)

IMPORTANT: If Item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 23334							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR						
KARL			W.		WILLIAMS	AUGUST 2, 1987			4:22AM								
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.					
MALE		BLACK		MONTH	5	DAY	19	YEAR	38	49			YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH										
MD		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			BALTIMORE CITY										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
BALTIMORE		THE JOHNS HOPKINS HOSPITAL								SELF EMPLOYED			N/A				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN BALTO.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			958 COLLINGTON AVE. 21205							
14. FATHER'S NAME FIRST JESSIE			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST BERTHA			MIDDLE	LAST	HORSEY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. N/A			17. INFORMANT PRESTON LeCATO 4041 CEDARDALE RD			ADDRESS								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Vascular Collapse.</i>										12 HRS.							
DUE TO, OR AS A CONSEQUENCE OF (b) <i>ImmunoBLASTIC LYMPHOMA</i>										6 mos.							
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>6/25</i> 19 <i>87</i> , to <i>8/2</i> 19 <i>87</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>8/2</i> 19 <i>87</i> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did not view the body after death.																	
22b. SIGNATURE <i>Fishel Zev Liberman</i>										DEGREE MD	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>8/2/87</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Fishel Zev Liberman</i>			22e. ADDRESS <i>John Hopkins Hospital</i>			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 8/7/87			23c. NAME OF CEMETERY OR CREMATORIAL MOUNT ZION CEMETERY			23d. LOCATION CITY OR TOWN LANSOWNE,		
24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H, INC.			ADDRESS 1101 E. NORTH AVE.			25a. DATE REC'D. BY REGISTRAR AUG 06 1987			25b. REGISTRAR'S SIGNATURE <i>Julia Sanderson-Randall</i>								

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Item 13 per phone

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 23335

1. DECEASED NAME LUCILLE Marie Williams			REG. NO.
2. SEX FEMALE	3. RACE Black	4. DATE OF BIRTH MONTH 03 DAY 08 YEAR 1891	5. DATE OF DEATH MONTH 8 DAY 12 YEAR 1987
6. BIRTHPLACE STATE OR FOREIGN COUNTRY MARY Maryland	7. CITIZEN OF WHAT COUNTRY USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. PLACE OF DEATH CITY OR COUNTY OF DEATH Baltimore City MD
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Liberty MED. CENTER	12. USUAL OCCUPATION UNEMPLOYED	13. KIND OF BUSINESS OR INDUSTRY Baltimore City MD
14. USUAL RESIDENCE IN NURSING HOME OR OTHER INSTITUTION GIVES RESIDENCE BEFORE ADMISSION 15. STATE Md.	15a. COUNTY BALTIMORE	15b. CITY OR TOWN BALTIMORE	15c. STREET ADDRESS / ZIP CODE 1620 Walbrook Ave 21216
16. FATHER'S NAME FIRST NOT KNOWN	MIDDLE John	17. LAST Dyson	18. MOTHER'S MAIDEN NAME FIRST Sallie
19. WAS DECEASED EVER IN U.S. ARMED FORCES (YES, NO OR UNKNOWN) No	20. SOCIAL SECURITY NO.	21. INFORMANT John Sydnor	ADDRESS 2503 Violet Ave Apt. 1109 S.
22. CAUSE OF DEATH (Enter only one cause per line for 1a), (b) and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (b) cardio-pulmonary arrest			
DUE TO, OR AS A CONSEQUENCE OF (b) sepsis			
DUE TO, OR AS A CONSEQUENCE OF (c) malnutrition with electrolyte imbalance			
23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a			
24. DATE OF OPERATION	25. CONDITION FOR WHICH OPERATION WAS PERFORMED	26. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	30. HOW INJURY OCCURRED (ENTER NAMES OF INJURERS IN ITEM 18, PART 1 OR PART 2)	
31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	32. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	33. LOCATION STREET	CITY OR TOWN COUNTY STATE
34. I certify that (I) not attended the deceased from 7/27/87 , 19 87 to 8/12/87 , 19 87 , and that in my (my) court opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
35. SIGNATURE TAH-DEEN I OHIOKPEHAI, MD	36. DEGREE	37. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	38. DATED SIGNED 8/12/87
39. PHYSICIAN'S NAME - TYPE OR PRINT TAH-DEEN I OHIOKPEHAI, MD	40. ADDRESS Liberty Medical Ctr		
41. BURIAL, CREMATION, REMOVAL (SPECIFY) B	42. DATE 8/12/87	43. NAME OF CEMETERY OR CREMATORIUM Baltimore Natl Cem	44. LOCATION CITY OR TOWN Baltimore
45. FUNERAL DIRECTOR NAME Joseph L. Russ	46. ADDRESS 222 W. Morel	47. DATE REC'D. BY REGISTERED REGISTRAR'S SIGNATURE AUG 13 1987 Julie DeLoach-Lindner	48. COUNTY MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, pages 1 and 2 should be filed or given to the State Dept. of Health and Mental Hygiene prior to burial or cremation, or mailed with the State Dept. of Health and Mental Hygiene prior to burial or cremation.

IMPORTANT: If item 21 is marked "Yes" or if items 18 or 19 above any entry, another separate certificate must be filed.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page # may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										23336	
										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>Rose</i>			<i>C</i>	<i>(W/111Ans)</i>	<i>8 27 87</i>	<i>8 27 87</i>	<i>AM</i>			<i>10 42 AM</i>	
3. SEX	4. RACE	5. DATE OF BIRTH									
<i>F</i>	<i>B2</i>	MONTH <i>7</i> DAY <i>25</i> YEAR <i>08</i>									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						9. BALTIMORE CITY OR COUNTY OF DEATH			
<i>VA</i>	<i>USA</i>	<i>BALTIMORE CITY</i>						MD			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
<i>BALTIMORE</i>	<i>BON SECOURS HOSPITAL</i>					<i>N/A</i>					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS / ZIP CODE			
<i>MD</i>	<i>BALTIMORE</i>	<i>BALTIMORE</i>						<i>2006 BOONE STREET 21218</i>			
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME					MIDDLE	LAST	
		<i>UNKNOWN</i>							<i>UNKNOWN</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>	16b. SOCIAL SECURITY NO. <i>216-34-6464</i>					17. INFORMANT					
						<i>KATTIE MAE GRIFFIN 2006 BOONE STREET</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coma - & shock</i>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) <i>Hepatic Failure, Kidney</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Failure & Anemia</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>8/14</i> , 19 <i>87</i> to <i>8/21</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>8/27</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Rosemary Sobansky</i>	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>8/28/87</i>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Rosemary Sobansky</i>	22e. ADDRESS <i>Bon Secours Hosp</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 9/1/87	23c. NAME OF CEMETERY OR CREMATORIAL MOUNT CALVARY CEM.	23d. LOCATION ANNE ARUNDEL CO.	23e. COUNTY	23f. STATE MD						
24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H 1101 E. NORTH 21202	ADDRESS	25a. DATE REC'D. BY REGISTRAR AUG 31 1987	25b. REGISTRAR'S SIGNATURE <i>Julia Sciarra-Lawless</i>								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 3 3 3 7

REG. NO.

1. DECEASED NAME FIRST (TYPE OR PRINT) TOMMY (TOMMIE)			MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
				WILLIAMS	AUGUST 18, 1987				12:30A _M
3 1. SEX	male	4. RACE	black	5. DATE OF BIRTH	MONTH 6	DAY 26	YEAR 1909	6. AGE (IN YEARS LAST BIRTHDAY)	78 YRS
3 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mississippi	7b. CITIZEN OF WHAT COUNTRY? U S A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY	10a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired	10b. KIND OF BUSINESS OR INDUSTRY				
10c. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL	12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 7804 Gay Wood Circle 21207			
14. FATHER'S NAME Charlie	MIDDLE	15. MOTHER'S MAIDEN NAME Mary	MIDDLE	MIDDLE		Middle	Martin		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 425-09-6843A	17. INFORMANT Flora Warren	ADDRESS 7804 Gay Wood Circle						
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary arrest							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks		
DUE TO, OR AS A CONSEQUENCE OF (b) sepsis									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) renal failure									
DUE TO, OR AS A CONSEQUENCE OF							10 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) above, (we) (did) (did not) view the body after death.	21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from Aug 2 , 19 87 , to Aug 18 , 19 87 , that (we) lost saw the deceased alive on Aug 18 , 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Jonathn Schlesstein</i>	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JONATHAN SCHLESSTEIN	22e. ADDRESS 650 N Wolfe Street Bet MD 21205								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8/21/87	23c. NAME OF CEMETERY OR CREMATORIAL Baltimore Cemetery	23d. LOCATION CITY OR TOWN Baltimore	COUNTY MD					
24. FUNERAL DIRECTOR Wm. C. March F/H West 4300 Wabash Avenue	25a. DATE REC'D. BY REGISTRAR AUG 19 1987	25b. REGISTRAR'S SIGNATURE <i>Julia Sanderson-Randall</i>							

23216 VHS 08/81

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23338

REG. NO.

6304 | AUG 18 1987

1. DECEASED NAME (TYPE OR PRINT)			MIDDLE INITIAL	1. DATE OF BIRTH MONTH DAY YEAR	11. DATE OF DEATH MONTH DAY YEAR	12. MONTH YEAR	13. HOUR 3:04 a.m.		
VIRGIL			H	WILLIAMS, Jr.	AUGUST 13, 1987				
2. SEX Male		3. RACE Black	4. DATE OF BIRTH MONTH DAY YEAR		5. AGE (IN YEARS LAST BIRTHDAY) 66 yrs		6. UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
			1	20	21				
7. BIRTHPLACE Md.		8. CITIZEN OF WHAT COUNTRY? USA	9. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY				
11. CITY OR TOWN OF DEATH BALTIMORE		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION THE JOHN'S HOPKINS HOSPITAL		13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		14. KIND OF BUSINESS OR INDUSTRY MD.			
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md.		16. CITY OR TOWN Balto.	17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		18. STREET ADDRESS / ZIP CODE 6614 Vincent Lane 21215				
19. FATHER'S NAME Virgil		MIDDLE INITIAL	20. Williams	21. MOTHER'S MAIDEN NAME Martha		PENN			
22. WAS DECEASED EVER IN U.S. ARMED FORCES? No		23. SOCIAL SECURITY NO. 213-14-0774		24. INFORMANT Dr. Robert Williams		25. ADDRESS 5036 Silver Hill Ct.			
26. CAUSE OF DEATH (Enter only ONE cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Progressive hypotension</u> 2 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, last DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sepsis</u> 2 days									
27. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 minutes									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
28. MEDICAL CERTIFICATION		29. DATE OF OPERATION		30. CONDITION FOR WHICH OPERATION WAS PERFORMED		31. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	32. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		33. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (SEE OTHER NOTICES MEDICAL EXAMINER)		34. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		35. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 34 OR PART 31)			
		36. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		37. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		38. LOCATION STREET	FLOOR OR TOWN	COUNTY	STATE
		39. I certify that (i) this hospital attended the deceased from since the deceased died on <u>8/13</u> 19 <u>87</u> , and that in my opinion death occurred on the date and hour and from the cause stated above, and (ii) did not view the body after death.		40. DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		41. DATE SIGNED 8/13/87			
		42. SIGNATURE <u>Lisa Esolen, MD</u>		43. ADDRESS 26 Spindrift Circle, Baltimore, MD.					
		44. PHYSICIAN'S NAME (TYPE OR PRINT) Lisa Esolen		45. NAME OF CEMETERY OR CREMATORIAL King Mem. Pk.		46. LOCATION CITY OR TOWN Randallstown, Md.			
47. BURIAL, CREMATION, REMOVAL TYPE Burial		48. DATE 8/18/87		49. NAME OF CEMETERY OR CREMATORIAL King Mem. Pk.		50. DATE REC'D. BY REGISTRAR AUG 17 1987			
51. FUNERAL DIRECTOR Wm C. March F/H West		52. ADDRESS 4300 Wabash Ave.		53. LOCATION CITY OR TOWN Randallstown, Md.		54. COUNTY COUNTY STATE			

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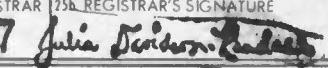
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 3 3 3 9

REG. NO.

062693

1- STATE
REGISTRAR

1. DECEASED NAME				FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTIMATED	<input type="checkbox"/>	MONTH	DAY	YEAR	1b. HOUR					
AUG 14 87				Imogene		Williamson	8	8	19	87	M						
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	1d. HOUR					
female	black	MONTH DAY YEAR 7 14 1928	59 yrs.	MONTHS DAYS	HOURS MIN		8	8	19	87	p						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH										
Md		U S A					Baltimore City MD										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY										
Baltimore		St. Agnes Hospital			Disabled												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS									
Md				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4405 Wakefield Road				21216					
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST								
Joseph				A11en	Estelle				Wilkens								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		216-20-6155		Hezekiah Williamson		4405 Wakefield Rd											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Diabetes mellitus																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE 												TITLE (SPECIFY) M.D. Deputy Chief MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.												DATE SIGNED 8/9/87					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE							
Burial		8/14/87		Garrison Forest Vet		Owings Mills				Md							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Wm. C. March F/H West		4300 Wabash Avenue		AUG 13 1987													

062683 100 1081

100 1081 062683

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER OR TO THE FUNERAL DIRECTOR; PAGE 3 SHOULD BE USED AS A BURIAL TRANSPORT SERVANT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

FOR ITEM 1, 17 Film G630 SB
1 - STATE REGISTRAR 8-11-87 per FH
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 3 3 4 0

REG. NO.

1. DEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH MATED	MONTH	DAY	YEAR	2b. HOUR			
Colleen Colleen			P.		Williar	<input checked="" type="checkbox"/>				8/ 2/ 1987			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS	8. IF UNDER 24 HRS. DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR 24 HOUR 8:53			
Female	White	March 19, 63	24 yrs.			<input checked="" type="checkbox"/>				P M			
7e. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH								
Maryland		USA			Baltimore City								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore		1627 Malvern Ave.			Service Rep. C&P Telephone								
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
Maryland				Baltimore		<input checked="" type="checkbox"/>		1627 Malvern St. 21224					
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
Earl		G.		Williar, Jr.		Carolyn				Nardone			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-84-2176			17. INFORMANT Winkler		ADDRESS Carolyn Williar 3118 Shortway 21222		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) Stab Wounds of Chest, Cutting Wound PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) of Neck and Strangulation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? XX 8/ 2/ 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject stabbed and strangled.									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET 1627 Malvern Ave., Balto. City, Md.		CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> TITLE (SPECIFY) Assistant MEDICAL EXAMINER													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St.								DATE SIGNED 8/3/87			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 8-6-87		23c. NAME OF CEMETERY OR CREMATORIAL Sacred Ht. of Jesus				23d. LOCATION CITY OR TOWN Baltimore Maryland		COUNTY			
24. FUNERAL DIRECTOR NAME		7922 Wise Ave. Dundalk, MD 21222								25a. DATE REC'D. BY REGISTRAR AUG 5 1987		25b. REGISTRAR'S SIGNATURE	

181818-VS-15



061506 AUG -4

-87 OR
STATE
REGISTRAR

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

334

REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 48 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN TEXT BOXES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.

PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER A ONE-MIL FORM, RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT FORM. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DIVISION OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS 2010 REGISTRATION UNIT 21201

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b HOUR			
ELWIN WILLIS						<input checked="" type="checkbox"/>				M			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS (LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR			
MALE	NEGROID	10-26-62	24 yrs.	MONTHS	DAYS	HOURS	MIN.			12:26			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		U. S. A.					Baltimore City						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Baltimore		Johns Hopkins Hospital			Unemployed		21218 Greenmount Ave						
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS	
		Md.				Baltimore						2615 Greenmount Ave	
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST				
Arthur Willis					Atlanta Faye								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-88-9791			17. INFORMANT		ADDRESS						
					Atlanta Willis		2615 Greenmount Ave						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of chest													
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF													
(c) DUE TO, OR AS A CONSEQUENCE OF													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							20. AUTOPSY?				
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:10PM 7-29-87			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
					subject shot								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Orleans Exxon			21f. LOCATION		STREET		CITY OR TOWN	COUNTY	STATE		
							1921 Orleans Street		Baltimore, Maryland				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Dennis F. Smyth, M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER												DATE SIGNED 8-2-87	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			111 Penn Street								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY/TOWNSHIP		23e. COUNTY		23f. STATE		
Burial		8-6-87		Mt. Calvary Cem.			Anne Arundel		County		Md.		
23g. FUNERAL DIRECTOR NAME		ADDRESS		1412 E. Preston St.			14h. DATE REC'D. BY REGISTRAR		14i. REGISTRAR'S SIGNATURE				
Calvin B. Scruggs							AUG 3 1987		Julia Johnson-Pandelle				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the Hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed and delivered to the attending physician, it may be removed from the carbon paper. Pages 1 and 2 should be retained for use on the burial permit. When placed in the envelope, attach the burial permit to the back of the certificate. With the State Dept. of Health and Mental Hygiene Print to be Cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any entry on other than a terminal event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

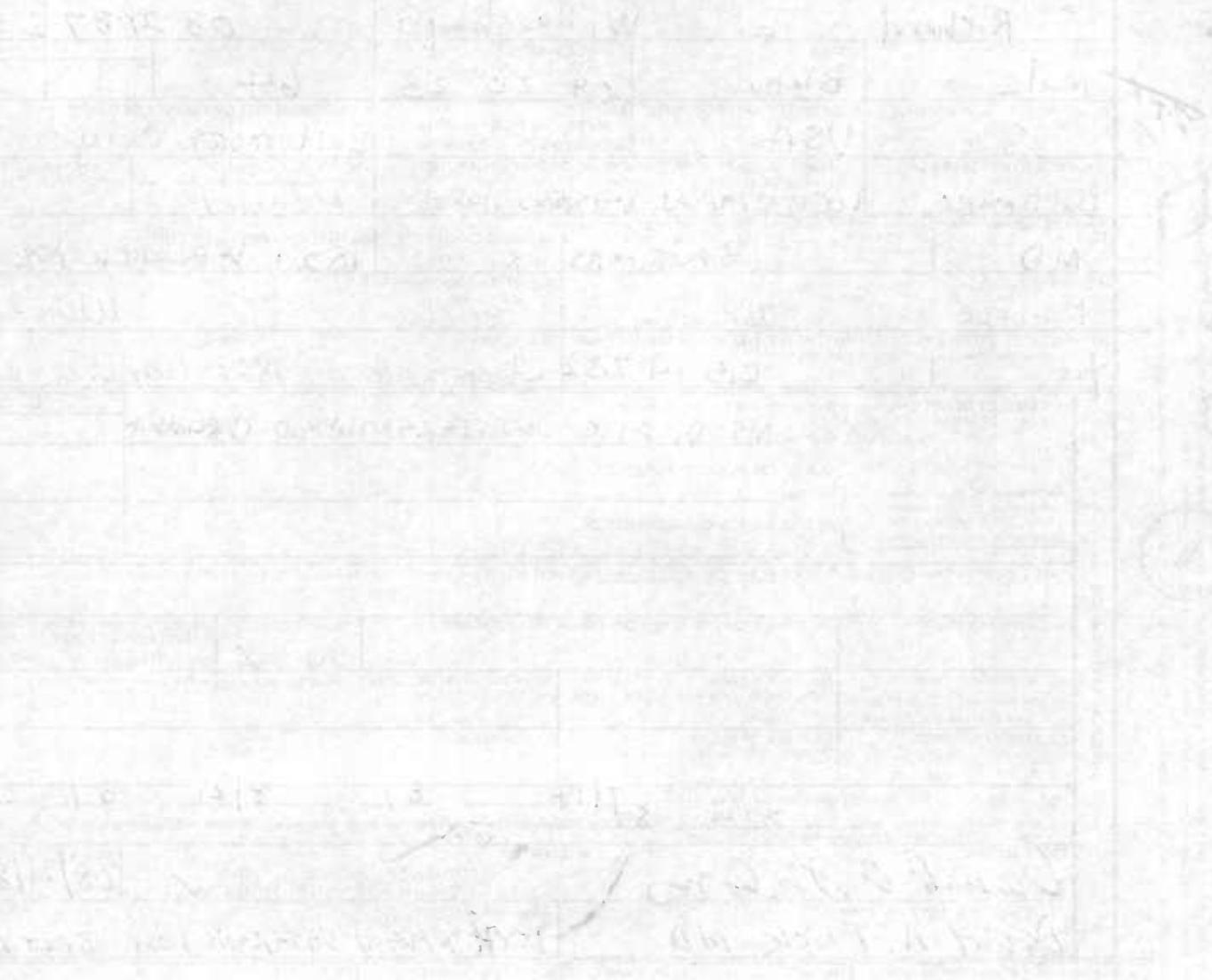
FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23342

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Richard			E.		Willoughby, Sr	08	21	87	2:35A M		
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male		Black	04 20 23			64			YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
S.C.		USA				Baltimore City					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		LOCH RAVEN VETERANS HOSP			Disabled						
13a. STATE		13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS ZIP CODE 1821 Warwick Ave 2216		
MD			Baltimore								
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST			
Monroe			Willoughby	Geneva				Warren			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES, NO OR UNKNOWN		16b. SOCIAL SECURITY NO. 215 14 7752			17. INFORMANT Jean Smith			ADDRESS 1821 Warwick Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC UNDIFFERENTIATED CARCINOMA											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7/17/87, 19 87, to 8/21, 19 87, that (I) (we) (did) (did not) last saw the deceased alive on 8/21, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE David A. Flick MD		22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22d. DATE SIGNED 08/21/87	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) David A. Flick MD		22f. ADDRESS LOCH RAVEN VETERANS HOSP BALT MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/25/87		23c. NAME OF CEMETERY OR CREMATORIAL Garrison Forest Vet			23d. LOCATION CITY OR TOWN Owings Mills		COUNTY	STATE	
24. FUNERAL DIRECTOR Wm. C. March F/H West 4300 Wabash Avenue		25a. DATE REC'D. BY REGISTRAR AUG 24 1987			25b. REGISTRAR'S SIGNATURE Julia Davidson Readall						

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23343

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
			JAMES	EDWARD	WILMORE	8	16	87				
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)						
MALE		BLACK	MONTH	DAY	YEAR	77	IF UNDER 1 YEAR		IF UNDER 24 HRS			
			12	27	10		MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH CITY						
MARYLAND		US				MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY		
BALTIMORE		613 NORTH CAREY STREET			RETIRED							
13a. STATE		13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			21217	
MARYLAND			BALTIMORE					613 NORTH CAREY STREET				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST			
		HARRY		WILMORE			CARRIE		BOWMAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS					
NO					CHART							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung Cancer APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost												
DO TO, OR AS A CONSEQUENCE OF (b)												
DO TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/11/87 to 8/16/87, that (I) (we) last saw the deceased alive on 8/11/87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) failed (did not) view the body after death.												
22b. SIGNATURE					DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS		2414 Pennsy/vania Ave,					
Paulette C. Hill												
23a. BURIAL, CREMATION, REMOVAL SPECIFY		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		23e. COUNTY STATE				
BURIAL		8-19-87		DRUID RIDGE CENT.		BALTIMORE		MARYLAND				
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
E.L. PHILLIPS		1721 N. MONROE ST.			AUG 18 1987		La Linda Laddell					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO 21 205 S 21 E 60

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23344			
												REG. NO.			
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			CORNELIUS H.			WILSON, Jr.			08 12 87			2:50 PM			
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
MALE			BLACK			09 08 82			454						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			BALTIMORE CITY MD.			
MARYLAND			U.S.A.												
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
BALTIMORE			NORTH CHARLES HOSPITAL						RETIRED USAF						
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
MD			ANNE			GLEN BURNIE						6529 BRICKTOWN CIRCLE 21061			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST												
Cornelius H. Wilson, Sr.			Mary Garner												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
YES			1949-1969			217-24-9171			Michelle Wilson 2335 Linden Ave. 21217						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RENAL FAILURE												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															
(b) HEPATO-RENAL FAILURE															
{ DUE TO, OR AS A CONSEQUENCE OF (c) HEPATIC CIRRHOSIS															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ESOPHAGEAL CA, Non SMALL CELL LUNG CA															
19a. DATE OF OPERATION 6/87			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ESOPHAGEAL CA			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURAL DEATH IN PART 1a OR PART 2) by highway									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 05-05-87, 19 87, to 08-12, 19 87, that (I) (we) lost saw the deceased alive on 08-12, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.															
22b. SIGNATURE Judith J. Santini MD			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED 08-12-87						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JUDITH J. SANTINI			22e. ADDRESS NORTH CHARLES AND 28TH ST BALTIMORE MD 21208												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 8-17-87			23c. NAME OF CEMETERY OR CREMATORIAL Garrison Forest Cemetery			23d. LOCATION CITY OR TOWN Owings Mills, COUNTY Maryland STATE						
24. FUNERAL DIRECTOR NAME Nutter Funeral Homes, Inc.			ADDRESS 2501 Gwynns Falls Pkwy			25a. DATE REC'D. BY REGISTRAR AUG 21 1987			25b. REGISTRAR'S SIGNATURE Julie Anderson-Gandy						
BP _____															
DHMH - 16 60M 7/84 (VRA 15, 4)															

0630825 25 Aug 19

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064207 X G 31-87 Film G631 Item 17 9-1-87
 TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. RETAIN PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH A COPY OF THE DEATH CERTIFICATE. PAGE 3 SHOULD BE USED AS A BURIAL TRANSFER FORM. PAGE 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												23343
												REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	1b. HOUR
Johnnie					Wilson	<input type="checkbox"/>			8/ 26/ 87			M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	1d. HOUR
M	B 2	3 27 02	85			<input checked="" type="checkbox"/>			8/ 26/ 87			12:12 P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH				
SC		U.S.A.						Baltimore City,				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore		1635 N. Bond Street			RETIRED			GRAY CONCRETE				
13a. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
MD				BALTO.		<input checked="" type="checkbox"/>		1635 N. BOND STREET 21213				
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST					
JAMES			WILSON	SARAH								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) . (IF YES, GIVE WAR ORDATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT Elizabeth		ADDRESS						
NO		244-03-5191		ROSA E. CARTER 803 LYNDHURST STREET								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under lying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(b) DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic Cardiovascular Disease												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20d. AUTOPSY?							
					<input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
		19										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE				
22a. I certify that I took charge of the remains described above, held on <input checked="" type="checkbox"/> Autopsy, <input type="checkbox"/> Inspection, <input type="checkbox"/> Inquiry, and in my opinion death resulted from <input checked="" type="checkbox"/> Natural cause, <input type="checkbox"/> Accidental, <input type="checkbox"/> Suicide, <input type="checkbox"/> Homicide, <input type="checkbox"/> Undetermined manner.												
ACTUAL SIGNATURE <i>Dennis F. Smyth, M.D.</i> TITLE (SPECIFY) ASSISTANT MEDICAL EXAMINER												
DATE SIGNED 8/27/87												
EXAMINER'S NAME (TYPE OR PRINT)		Dennis F. Smyth, M.D.			ADDRESS			111 Penn St.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN		COUNTY	STATE		
BURIAL		8/31/87		BALTIMORE CEMETERY			BALTIMORE,			MD		
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE RECEIVED BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
WM. C. MARCH F/H, INC.		1101 E. NORTH AVE.			AUG 28 1987			<i>[Signature]</i>				

18 16 815 10 8180

18 16 815

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23340

FOR
STATE
REGISTRAR

REG. NO.

064294 AUG 31 1987

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed, it should be detached for use on the burial permit. Then place the death certificate in the envelope provided and mail it, together with the State Dept. of Health and Mental Hygiene price of burial permit, to the State Department of Health and Mental Hygiene, P.O. Box 120, Annapolis, Maryland 20702.

IMPORTANT: If item 21 is marked or if item 18 shows any injury or other symptomatic event, the medical examiner must be notified prior to burial.

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR P												
KEITH GREY WILT				AUGUST 27, 1987				10:55 M															
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.															
Male		Caucasian		Month Day Year April 25 1911		76 YRS.		IF UNDER 24 HRS MONTHS DAYS HOURS MIN.															
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.															
w. Virginia		U.S.A.				BALTIMORE CITY																	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY																	
BALTIMORE		THE JOHNS HOPKINS HOSPITAL		State Park Engineer		State Md																	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. STATE				13c. COUNTY				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE							
				Maryland				U. S. A.				BALTIMORE				230 S. Lachan 21227							
14. FATHER'S NAME				FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		FIRST		MIDDLE		LAST							
George				—		—		WILT		SARAH		Elizabeth		Hamilton									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
NO				235-30-1167				Wesley G. Wilt				36-29 Cornwall Rd				1 minute							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				Respiratory Arrest															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b)				DUE TO, OR AS A CONSEQUENCE OF Metastatic Transitional Cell Cancer of Bladder 2 months															
				(c)				DUE TO, OR AS A CONSEQUENCE OF Localized Transitional Cell Cancer of Bladder 16 years															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
Cheronic Obstructive Pulmonary Disease																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)				21f. LOCATION STREET				CITY OR TOWN				COUNTY				STATE			
22a. I certify that (I) (this hospital) attended the deceased from August 25 1981 to August 27 1981, that (II) we last saw the deceased alive on August 27 1981, and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) (we did) (did not) view the body after death.																							
22b. SIGNATURE				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED				8/27/87							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				Patrick Hwu, MD				22e. ADDRESS				The Johns Hopkins Hospital, Baltimore, MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORIUM				23d. LOCATION CITY OR TOWN				COUNTY				STATE			
Burial				08/31/87				Holly Hill Mem. Good Misch River Baltimore				Baltimore											
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE											
Mark A. Chojnacki P.A.				1800 E. Lombard St.				21231				AUG 28 1987				Julia Deacon 8/28/87							

064584 VUE 31 05

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please attach item 20 on papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or cremation.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 23347
DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR		
MANY					WINBUSH	8	27	87	3 ¹⁵			
3. SEX	F	4. RACE	B2	S. DATE OF BIRTH	MONTH	DAY	YEAR	6 AGE (IN YEARS LAST BIRTHDAY)				
				5	30	16	IF UNDER 1 YEAR					
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?	MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	71 YRS				
GLOUFSCHESTER, VA.			U.S.A.					9 BALTIMORE CITY OR COUNTY OF DEATH Balto. MD.				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Balto. Medical Center					12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
MD			13b STATE	13b COUNTY	13c CITY OR TOWN	BALTO.	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS / ZIP CODE 2210 ROSLYN AVE. 21216	12b KIND OF BUSINESS OR INDUSTRY			
14. FATHER'S NAME FIRST WILBERT WRIGHT			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NELLIE HOLMES							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b SOCIAL SECURITY NO.		17. INFORMANT JOHN E. WINBUSH 2210 ROSLYN AVE.							
NO N/A								ADDRESS				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute G.I. Bleed					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			{ (b) }									
			DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CHF, PROBABLE SEPSIS												
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a I certify that (I) this hospital attended the deceased from 8/27/87 to 8/27/87, that (I) we last saw the deceased alive on 8/27/87, and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.												
22b. SIGNATURE R. SHER		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 8/27/87						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. SHER		22e ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/1/87		23c. NAME OF CEMETERY OR CREMATORIAL KING MEM. PK.		23d. LOCATION CITY OR TOWN BALTO., MD.		23e COUNTY BALTO., MD.				
24 FUNERAL DIRECTOR NAME LEROY O. DYETT		ADDRESS 4600 LIBERTY HEIGHTS		25a. DATE RECEIVED AUG 28 1987		25b. REGISTRATION NUMBER Julia Anderson-Ladner						

1810 AM 066400

Temporary duty 1st & 2nd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked "No" then Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23348	
												REG. NO.	
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			Catherine E. Winters						8 8 87			10 5 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Female		White		Oct. 30, 1898			88 yrs.						
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH City MD.						
Maryland		USA.											
10. CITY OR TOWN OF DEATH Baltimore		11. NURSING HOME OR OTHER INSTITUTION JEWISH HOSPITAL NURSING HOME Home (IF NOT INSTITUTION, GIVE STREET ADDRESS) 1000 S. Caton Ave. 21229		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk			12b. KIND OF BUSINESS OR INDUSTRY Railroad						
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Glyndon			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 3 Fiske Ave. 21071			
14. FATHER'S NAME Edward		MIDDLE Charles		LAST Winters			15. MOTHER'S MAIDEN NAME FIRST Mary			MIDDLE LAST Riley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 705-12-2092		17. INFORMANT James Winters Baltimore, Md. 21207									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Odem & Carcinoma colon</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2+ yr	
DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN				
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 8/12/85, to 8/8/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.									COUNTY STATE				
22b. SIGNATURE <i>Lorraine J. Berger, M.D.</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 88-87				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/11/87			23c. NAME OF CEMETERY OR CREMATORIAL All Saints Cemetery			23d. LOCATION CITY OR TOWN Reisterstown COUNTY Baltimore, Md. STATE				
24. FUNERAL DIRECTOR NAME <i>Patty Highsmith</i>			ADDRESS Eckhardt Funeral Chapel Owings Mills, Md. 21117			25a. DATE REC'D. BY REGISTRAR AUG 10 1987			25b. REGISTRAR'S SIGNATURE <i>Julia Seiden-Bradare</i>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper from item 21 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event,

MEDICAL CERTIFICATION

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 3 3 4 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
ETHEL E WISE						08/18/87				10:38 M	
3. SEX		4. RACE	B2	5. DATE OF BIRTH MONTH 06 DAY 10 YEAR 86		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
F						81					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD.			
Maryland		U.S.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
BALTIMORE CITY		UNIVERSITY OF MARYLAND		TEACHER		Balto City					
13a. STATE MD		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 525 N. CALHOUN ST / 21223					
14. FATHER'S NAME FIRST John MIDDLE I. LAST Wise		15. MOTHER'S MAIDEN NAME Addie									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 212-36-9266		17. INFORMANT Sarah Wise 1602 Fort Davis Place S.E. Washington		ADDRESS					
No											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		RESPIRATORY ARREST				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
						1 HOUR					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DO TO, OR AS A CONSEQUENCE OF (b) HEMODYNAMIC DECOMPENSATION				3 HOURS					
		DO TO, OR AS A CONSEQUENCE OF (c) SEPSIS				7 HOURS					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from Aug 18 19 87 to Aug 18 19 87, that (I) (we) lost saw the deceased alive on 18 AUG 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.		22b. SIGNATURE Sean Tunis		DEGREE		22c. DATE SIGNED 8/18/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SEAN TUNIS		22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 8-24-87		23c. NAME OF CEMETERY OR CREMATORIAL Arbutus Memorial Park		23d. LOCATION CITY OR TOWN Arbutus		STATE Maryland			
24. FUNERAL DIRECTOR NAME Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy		ADDRESS		25a. DATE REC'D. BY REGISTRAR AUG 21 1987		25b. REGISTRAR'S SIGNATURE Julie Davidson Rendell					

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TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be

referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma at time of death, the medical examiner must be notified at once.

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2 3 3 5 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Zofia</i>	MIDDLE	LAST <i>Wisniewski</i>	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
						<i>August 17, 1987</i>				<i>10 PM</i>		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
<i>Female</i>		<i>White</i>		MONTH <i>5</i>	DAY <i>15</i>	YEAR <i>87</i>	80	MONTHS <i>0</i>	YEARS <i>0</i>	HOURS <i>10</i>	MIN. <i>PM</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED X NEVER MARRIED WIDOWED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.				
<i>Maryland</i>		<i>U.S.A.</i>		<input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<i>Baltimore City</i>						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
<i>Baltimore</i>		<i>314 Elrino Street</i>		<i>Retired</i>		<i>Clothing</i>						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
<i>Md.</i>				<i>Baltimore</i>				<i>314 Elrino Street 21224</i>				
14. FATHER'S NAME		FIRST <i>Peter</i>	MIDDLE <i>Siek</i>	LAST <i>Francesca</i>	15. MOTHER'S MAIDEN NAME							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
<i>No</i>		<i>218-44-2856</i>		<i>Stefan Wisniewski Sr.</i>		<i>314 Elrino St. 21224</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>CARDIAC ARREST</i>												
DUE TO, OR AS A CONSEQUENCE OF (b) _____												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Kenneth Williams</i>		22c. DEGREE <i>MD</i>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <i>8-17-87</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>KENNETH WILLIAMS</i>		22e. ADDRESS <i>740 S. Conkling St.</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>8-21-87</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Saint Stanislaus</i>		23d. LOCATION CITY OR TOWN <i>Baltimore City, Md.</i>		23e. COUNTY		STATE		
24. FUNERAL DIRECTOR NAME <i>Charles S. Zeiler & Son Inc.</i>												
ADDRESS <i>6224 Eastern Ave.</i>												
25. DATE REC'D. BY REGISTRAR <i>AUG 19 1987</i>												
25b. REGISTRAR'S SIGNATURE <i>Julia S. Zeiler</i>												

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 4 may be retained by the funeral director and filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Negro, page 18 shows any injury, or other traumatic event, the death certificate should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

FOR STATE FEDERAL			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			-2 3 3 5		
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
IDA LOWE			WOLF	August 26, 1987				
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 1, 1899	6. AGE (IN YEARS LAST BIRTHDAY) 87	IF UNDER 1 YEAR MONTHS YRS		IF UNDER 24 HRS HOURS MIN.		
7. BIRTHPLACE COUNTRY MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5822 Halwyn Avenue			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary			12b. KIND OF BUSINESS OR INDUSTRY Office	
13a. STATE MD	13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5822 Halwyn Ave., 21212				
14. FATHER'S NAME FIRST William	MIDDLE Lowe	LAST	15. MOTHER'S MAIDEN NAME FIRST Emma	MIDDLE	LAST Sharrer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213 05 9777	17. INFORMANT Roger Saltzgaver, Reisterstown, MD	ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) AS CVD.								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____ 19_____, to _____ 19_____. that (he) was last seen the deceased alive on Aug. 19 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.								
22b. SIGNATURE <i>Stephen Laiken</i>	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 8/26/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Stephen Laiken, MD	22e. ADDRESS 6805 York Road, Balto., MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8/28/87	23c. NAME OF CEMETERY OR CREMATORIAL St. Johns	23d. LOCATION CITY OR TOWN Westminster	23e. COUNTY	23f. STATE			
24. FUNERAL DIRECTOR NAME H.W. Jenkins	ADDRESS 21212	25a. DATE REC'D. BY REGISTRAR AUG 27 1987	25b. REGISTRAR'S SIGNATURE <i>Julia Sanders-Ladeau</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The retained by the hospital or attending physician.

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper, page 3, and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or interment.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2352

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LUTHER J. WOLF			FIRST	MIDDLE	LAST	2a. DATE OF DEATH August 17, 1987	MONTH	DAY	YEAR	2b. HOUR 5:07 M		
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH J DAY 3 YEAR 1915				6. AGE (IN YEARS LAST BIRTHDAY) 72	IF UNDER 1 YEAR MONTHS YRS. DAYS			IF UNDER 24 HRS. HOURS 5 MIN. 07		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md	7b. CITIZEN OF WHAT COUNTRY? USA	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City,						
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1607 Sherwood Ave.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret Trust Officer			12b. KIND OF BUSINESS OR INDUSTRY Banking					
13a. STATE Md.	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1607 Sherwood Ave. 21239								
14. FATHER'S NAME FIRST 	MIDDLE 	LAST Wolf	15. MOTHER'S MAIDEN NAME FIRST Annetta	MIDDLE J	LAST Dannenfelser							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW11	16c. SOCIAL SECURITY NO. 217 09 3925	17. INFORMANT Irene Hall Wolf	ADDRESS Same								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			<i>Carcinoma of Lung & Brain</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) <i>+ Liver Metastasis</i>									
{ DUE TO, OR AS A CONSEQUENCE OF (c) <i> </i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).												
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY 19 YEAR P.M. 			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 								
22a. I certify that (I) (this hospital) attended the deceased from 8/7/87 to 8/7/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											22b. DATE SIGNED 8/17/87	
22c. SIGNATURE DONALD W. MINTZER			DEGREE MD.	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD W. MINTZER			22e. ADDRESS 3009 EVERGREEN Ave Baltimore, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8/20/1987	23c. NAME OF CEMETERY OR CREMATORIAL Parkwood Cemetery	23d. LOCATION CITY OR TOWN Baltimore, Md.	23e. COUNTY 	23f. STATE 							
24. FUNERAL DIRECTOR NAME MITCHELL-WIEDEFELD HOME, INC.	ADDRESS 6500 York Rd.	25a. DATE REC'D. BY REGISTRAR AUG 20 1987			25b. REGISTRAR'S SIGNATURE Julia Gordon Leader							

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Item #15 G 630 8/21/87 cw

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23353

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST PEARL	MIDDLE AGNES	LAST WOLF	2a. DATE OF DEATH 08/17/87	MONTH YEAR	DAY	YEAR	2b. HOUR 1420 M				
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH 05			DAY 04	YEAR 97	6. AGE (IN YEARS LAST BIRTHDAY) 90	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS. HOURS HRS.	MIN. MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY					
10. CITY OR TOWN OF DEATH BALTIMORE CITY			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) operator			12b. KIND OF BUSINESS OR INDUSTRY Telephone Co.					
13a. STATE Maryland			13b. COUNTY Baltimore			13c. CITY OR TOWN Arbutus			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 5527 Oregon Avenue		
14. FATHER'S NAME FIRST John			MIDDLE J.			LAST Wolf, Sr.			15. MOTHER'S MAIDEN NAME FIRST Minnie			LAST Strube		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) n/a			16b. SOCIAL SECURITY NO. 212-05-0004			17. INFORMANT Lillian Wolf 5527 Oregon Ave, 21227			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest with brach & Asyst DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aspiration pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Hypoxia														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Alzheimer's disease														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 8/12/87 to 8/17/87 , 19 87 , that (I) (we) last saw the deceased alive on 8/17/87 , 19 87 ; and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (II) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Ahmed Hossari			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ahmed Hossari			22e. ADDRESS St agnes Hospital 5900 Scalon Ave											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 08/20/87			23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery			23d. LOCATION CITY OR TOWN Baltimore			COUNTY STATE Md.		
24. FUNERAL DIRECTOR NAME Ambrose Funeral Home			ADDRESS 1328 Sulphur Spring Rd.			25a. DATE REC'D. BY REGISTRAR AUG 18 1987			25b. REGISTRAR'S SIGNATURE J. J. J.					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon copy of this certificate and mail to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. If item 21 is marked "yes", medical examiner must be notified.

IMPORTANT: If item 21 is marked "yes", item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's file. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	REG. NO.		
Rufus Lester Wolfe						23354		
3. SEX	4. RACE	5. DATE OF BIRTH	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Male	White	August 13, 1896	August 22, 1987				6:20 pm	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS				IF UNDER 24 HRS HOURS MIN.	
Maryland	U.S.A.	91						
8. CITY OR TOWN OF DEATH			9. BALTIMORE CITY OR COUNTY OF DEATH				MD.	
Baltimore			Baltimore City					
10. USUAL RESIDENCE IF NURSING HOME OR OTHER INSTITUTION. GIVE RESIDENCE BEFORE ADMISSION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland	13b. COUNTY Frederick	13c. CITY OR TOWN Smithsburg	Farm Laborer				Farm	
14. FATHER'S NAME			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 12816 Loy Wolfe Road/21783	
FIRST Henry	MIDDLE Lee	LAST Wolf	15. MOTHER'S MAIDEN NAME FIRST Ida MIDDLE Virginia LAST Kline					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 220-46-5622				17. INFORMANT Cyrus Wolf	
							ADDRESS 12816 Loy Wolfe Road Smithsburg, MD 21783	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY								
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>								
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Anoxic Encephalopathy</u>								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>August 17, 1987</u> to <u>August 22, 1987</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>August 22, 1987</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death.								
22b. SIGNATURE <i>Ugur Camli</i>	DEGREE M.D.				ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 8/22/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) UGUR CAMLI	22e. ADDRESS Maryland General Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-26-87	23c. NAME OF CEMETERY OR CREMATORIAL Smithsburg Cemetery	23d. LOCATION CITY OR TOWN Smithsburg	COUNTY Washington	STATE Maryland			
24. FUNERAL DIRECTOR <i>Ricketts</i> Ricketts Funeral Home	ADD'L Myersville, MD 21773	25a. DATE REC'D. BY REGISTRAR AUG 28 1987				25b. REGISTRAR'S SIGNATURE <i>Gina Dawson-Randall</i>		

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TOP SECRET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 23355	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
Ernest					Womack	8	14	87		M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH 8 DAY 3 YEAR 95			6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City			MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2519 Oswego Ave.			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2519 Oswego Avenue 21215		
14. FATHER'S NAME FIRST Abe		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST Silvia							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 231-36-1257			17. INFORMANT Ruby Bowman			ADDRESS 2519 Oswego Ave.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.V.A.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF b) Hypertension c) multiple emboli's											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (this hospital) attended to deceased from 8/1/87, 19, to 8/13, 19, that (I/we) last saw the deceased alive on 8/13, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did not see the body after death.											
22b. SIGNATURE <i>Claudio Levin MD</i>		22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 8/17/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Claudio Levin MD		22e. ADDRESS 10219 S. Dolfield Rd. Owings Mills									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/19/87		23c. NAME OF CEMETERY OR CREMATORIAL King Mem Pk.			23d. LOCATION CITY OR TOWN Randallstown, Md.			COUNTY	STATE
24. FUNERAL DIRECTOR NAME Wm C March F/H West		ADDRESS 4300 Wabash Ave.			25a. DATE REC'D. BY REGISTRAR AUG 17 1987			25b. REGISTRAR'S SIGNATURE Julia Davidson-Lindsey			
DHMH - 16 60M 7/84 (VRA 15, 4)											

3040 V.A. 186

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be left within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										23356			
										REG. NO.			
DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR		
Richard					Wood, Jr.	8/30/87							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
M		B		1 13 1915			72		YRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH City		MD.				
Va.		USA											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Balto. Francis Scott Key								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steelworker			
13a. STATE Md.		13b. COUNTY Balto		13c. CITY OR TOWN Turners			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 535 Main Street 21222				
14. FATHER'S NAME FIRST Richard		MIDDLE Wood		LAST			15. MOTHER'S MAIDEN NAME FIRST Maude		MIDDLE Booker		LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 223 24 7746		17. INFORMANT Marilyn Thrower			ADDRESS 107 Avon Beach		21222				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio Pul A.R.A.E.</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Old CVA</i>													
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Dm</i>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 9.2.87	
22b. SIGNATURE <i>[Signature]</i>			22c. DEGREE <i>[Degree]</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Burial			22e. ADDRESS Midway C. Cemetery Cumberland										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/4/87		23c. NAME OF CEMETERY OR CREMATORIAL Midway C. Cemetery Cumberland			23d. LOCATION CITY OR TOWN		COUNTY	STATE		
24. FUNERAL DIRECTOR NAME Tas. A. Morton & Sons			ADDRESS 1701 Laurens St.			25a. DATE REC'D. BY REGISTRAR/REGISTRAR'S SIGNATURE SEP 04 1987 Julie Wilson-Rondell							
DHMH - 16 60M 7/84 (VRA 15, 4)													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please return pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other fracture, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										23357								
										REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR	
Richard B. Woodard												08 21 87					1050P.M.	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS				
Male			Black			Month Day Year April 12-28			59 YRS			MONTHS DAYS		HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Baltimore S.C.			U.S.A.						Baltimore City									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Baltimore			Mercy Hospital			Laborer			Factory									
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE						
Md.						Baltimore						2120 E. Federal St. 21213						
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME												
Richard			Woodward			Unknown												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS									
? ?			251-38-9669			Jessie Davis			2108 E. Federal St.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
IMMEDIATE CAUSE (a) Possible Septicemia																		
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Lung Cancer																		
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
									YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>			STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
Keith E. Reed															08/21/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY				23f. STATE		
Burial			8-27-87			Mt Calvary Cemetery			Cedar Hill			Pa. Co. Md.						
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
Randolph J. Collett			24316 Oliver St.			AUG 28 1987			John Dearden-Randall									

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The law requires that the death sentence be executed within 24 hours after death. Page 4 may be TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death sentence be executed within 24 hours after death. Page 4 may be

TO HOSPITAL OR ATTENDING PHYSICIAN: The

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then pages 1, 2 and carbon papers, Pages 1 and 2 should be filed within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23550

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	REG. NO.
ANNA M. WOODLAND						AUGUST 24, 1987
3. SEX		4. RACE		5. DATE OF BIRTH		2d. DATE OF DEATH MONTH DAY YEAR
FEMALE		BLACK		MONTH	DAY	YEAR
1. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		6. AGE (IN YEARS LAST BIRTHDAY) YRS.
ALABAMA		U. S. A.				IF UNDER 1 YEAR MONTHS DAYS
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY Dept. of EDUCATION
BALTIMORE		MARYLAND GENERAL HOSPITAL		Special Sub. Teacher		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Maryland				Baltimore		13e. STREET ADDRESS / ZIP CODE
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME
FIRST			MIDDLE	LAST		
Unknown			Unknown		Sallie	Davis
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS
(If Yes, give war or dates)		212-42-0604		DR.		Columbia, Maryland 21044
No.		George F. Woodland				10131 Goodbody Court
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY:						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) RESPIRATORY ARREST						
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASPIRATION PNEUMONIA; SEVERE ARTERIOSCLEROSIS						
DUE TO, OR AS A CONSEQUENCE OF (c) POSSIBLE MYOCARDIAL INFARCTION						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN COUNTY STATE
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 20, 1987 to August 24, 1987, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 24, 1987, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> view the body after death.						22b. SIGNATURE
						DEGREE
						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				22f. DATE SIGNED
Fadi Matar, M.D.		c/o Maryland General Hospital				8/28/87
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN COUNTY STATE
Burial		8/28/1987		New Cathedral Cemetery		Baltimore, Maryland
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE OF DAY OF REGISTRATION		25b. REGISTRAR'S SIGNATURE
FUNERAL HOMES, INC.				AUG 28 1987		
2501 Gwynns Falls Pkwy. Baltimore, Md. 21216						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene Director of Burial, Cremation or Removal.

IMPORTANT: If Item 21 is marked or Item 18 shows an injury or other traumatic event, the medical examiner must be notified of such.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 23357	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	20b. HOUR	
WILLIAM H. WOODSON						8/29/87				0700	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
MALE		BLACK		MONTH	DAY	YEAR	66	YRS	MONTHS	IF UNDER 24 HRS	
10a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
VA		USA					BALTIMORE CITY MD.			N/A	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION					12b. KIND OF BUSINESS OR INDUSTRY				
BALTIMORE		UNION MEMORIAL HOSPITAL					BETHELHAM				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a STATE	
13b CITY OR TOWN										13c CITY OR TOWN	
BALTIMORE										BALTIMORE	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e STREET ADDRESS / ZIP CODE	
MD										5551 MIDWOOD AVENUE 21212	
14. FATHER'S NAME FIRST		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST
UNKNOWN		UNKNOWN			UNKNOWN			UNKNOWN			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR GATES)		17 INFORMANT			ADDRESS				
NO		229-22-0976		WILLIAM WOODSON JR. 1635 N. SPRING STREET							
18 CAUSE OF DEATH Enter only one cause per line for 1a, 1b, and 1c.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Lung Ca</i>										8 months	
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Oliguric Renal failure</i>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
				YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <i>8/22/87</i> , 19 <i>87</i> , to <i>8/29/87</i> , 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>8/28/87</i> , 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Gene Kim</i>		22c. DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED <i>8/29/87</i>				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Gene Kim MD</i>		22f. ADDRESS <i>Union Memorial Hosp Balt 21218</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE <i>9/2/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>CEDAR HILL CEMETERY</i>			23d. LOCATION CITY OR TOWN <i>ANNE ARUNDEL CO</i>			COUNTY	STATE
24. FUNERAL DIRECTOR NAME <i>WM. C. MARCH F/H</i>		ADDRESS <i>1101 E. NORTH AVENUE 21202</i>		25a. DATE REC'D. BY REGISTRAR <i>AUG 31 1987</i>			25b. SIGNATURE <i>Julia Scitton-Reader</i>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, hand completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certification section must be completed in order for the death certificate to be issued.

1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23360

REG. NO.

DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
			Paul	Burgess	Woolfrey	8	12	87		4:05 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		Jan. 14, 1929		58		MONTHS	YEARS	HOURS	MIN.
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
Orange Virginia		U. S. A.						Baltimore City			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Baltimore		Francis Scott Key meal Center		Laborer		Ship Yard					
13a. STATE		13b. COUNTY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE					
Maryland		Baltimore		YES <input checked="" type="checkbox"/>		1150 Quantril Way 21205					
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME						
		Ernest	Clifton	Woolfrey	Hazel		MIDDLE	LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
no		214 26 9212		Ellis Woolfrey		Baltimore, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>		minutes									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metabolic Acidosis</u> days									
{		DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Coronary Artery Disease, COPD, Coagulopathy											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/12 1987 to 8/12 1987, that (I) (we) lost saw the deceased alive on 8/12 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>H. Jeffrey Schwartz, MD</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/12/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>H. Jeffrey Schwartz</u>		22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 8/17/87		23c. NAME OF CEMETERY OR CREMATORIAL Zoar Church		23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE	
24. FUNERAL DIRECTOR NAME W. C. Johnson		ADDRESS Locust Grove, Va.		25a. DATE REC'D. BY REGISTRAR AUG 18 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Johnson-Kendall</u>					

063108 VME 1005

062977 AUG

FOR
STATE REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH23361
REG. NO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 2 and 2a should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	26. HOUR	
L. HALSIE			L.	WORLEY		August	11	1987	9 50 A M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		June 30, 1902		85		YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Virginia		U.S.A.				BALTIMORE					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
BALTIMORE CITY		UNION MEMORIAL HOSPITAL		Factory Worker		Manufacturing					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland		-		Baltimore				3519 Ash Street 21211			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST		
William Hile					Lillian Kniceley						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		216 03 3546		Margaret Broyles		3519 Ash St., 21211					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Cardiac Arrest											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) Myocardial Infarction									
{		DUE TO, OR AS A CONSEQUENCE OF									
(c)		{		DUE TO, OR AS A CONSEQUENCE OF							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 2 OR PART 21)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from August 8, 1987, to August 11, 1987, that (I) (we) last saw the deceased alive on August 11, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED					
Alan Jeffrey Krantthal						8/11/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		Union Memorial Hospital Baltimore, Md. 21218							
Alan Jeffrey Krantthal											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY	STATE		
Cremation				Westview Crematory		Winters Lane, Balt., Md. 21228					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Burgee-Henss Funeral Home		3631 Falls Rd.		AUG 17 1987		Leigh Pendell					
BP											
DHMH - 16 60M 7/84 (VRA 15, 4)											

062021 100 100

100 100 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to the issuance of this certificate.

FOR
STATE
REGISTRAR

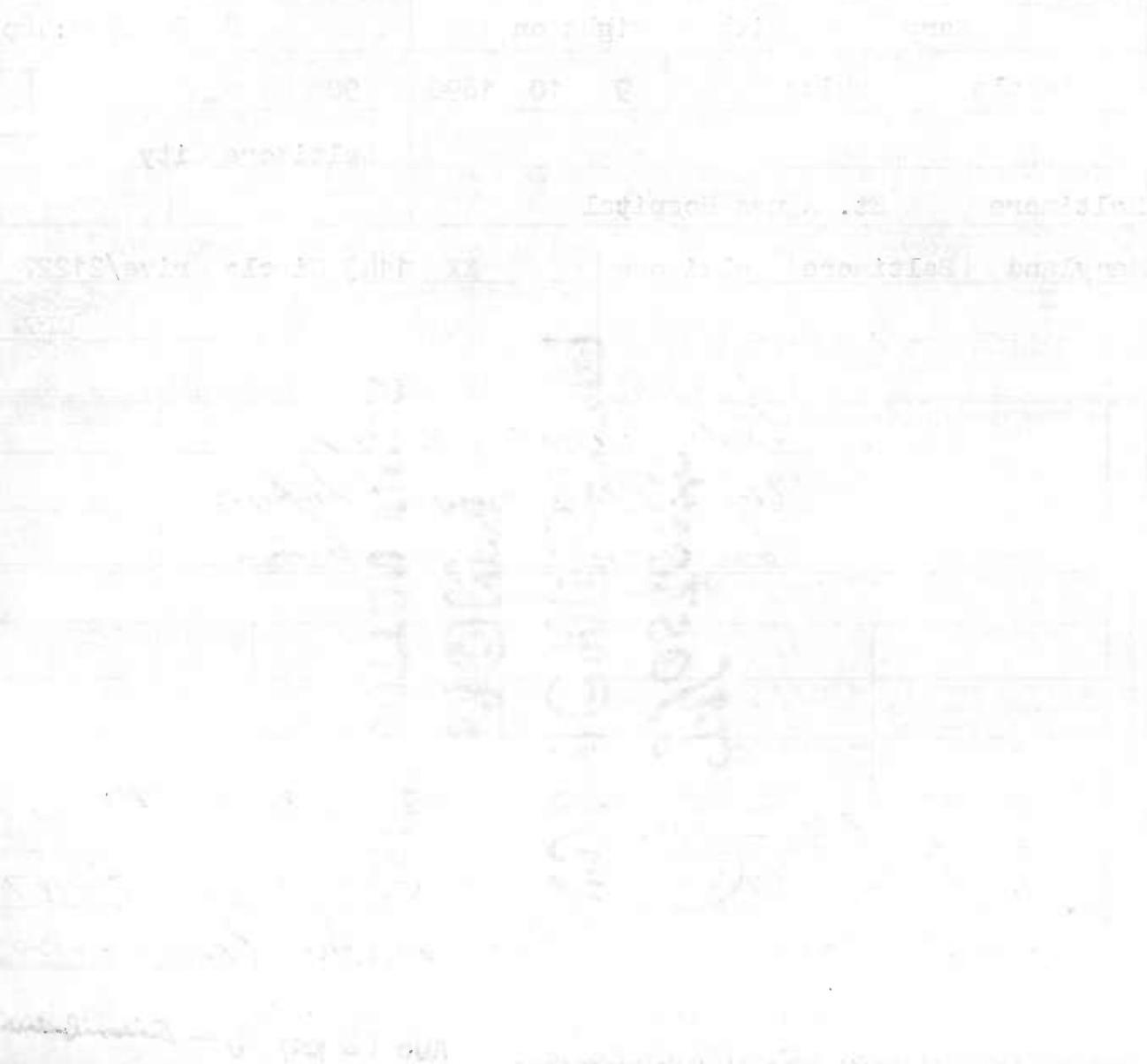
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23362

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
			MARY	EDITH	WRIGHTSON	8	9	87	8:46p				
3. SEX			4 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
FEMALE			WHITE	MONTH	DAY	YEAR	90	YRS		IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
MARYLAND			U.S.A.						Baltimore City MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore			St. Agnes Hospital			SALESPERSON			STEWART'S DEPT. STORE				
13a. STATE			13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
Maryland			Baltimore	Arbutus						1143 Circle Drive/21227			
14. FATHER'S NAME			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> (IF YES, GIVE WAR OR DATES) NO			17. INFORMANT		
JEREMIAH			B.	WRIGHTSON	BESSIE			18a. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Endo Respiratory Areas</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Myocardial Hypertrophy</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <i>General debilitation</i> DUE TO, OR AS A CONSEQUENCE OF			ADDRESS		
18b. SOCIAL SECURITY NO.			19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
215-03-2150													
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I													
20a. DATE OF OPERATION			20b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20c. AUTOPSY?			20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>7/30</i> 19 <i>87</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.													
22b. SIGNATURE <i>John C. Hickey M.D.</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>8/9/87</i>				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John C. Hickey</i>			22f. ADDRESS <i>1311 Frederick Ave. Baltimore, MD 21227</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE BURIAL 8/13/87			23c. NAME OF CEMETERY OR CREMATORIAL LOUDON PARK CEMETERY			23d. LOCATION CITY OR TOWN BALTIMORE				
24. FUNERAL DIRECTOR HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.						25a. DATE REC'D. BY REGISTRAR <i>AUG 12 1987</i>			25b. REGISTRATION NUMBER <i>John C. Hickey</i>				

005481 May 13 1981



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper from pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										23363		
										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
JOHN			J.	YEOMANS		8/6/87						900P.M.
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Male			White		MONTH 10/13/10 YEAR			76			MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS.	
Rhode Island			USA					BALTIMORE			YRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
TOWSON			GBMC-6701 NORTH CHARLES ST.			General Mgr.			Auto Industry			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Maryland			Baltimore		Cockeysville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		10327 B Malcolm Circle, 21030			
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST			
William				Yeoumans	Elizabeth				Stritch			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			
No			035-10-2709			Margaret N. Yeoumans, same as 13e.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 MINUTES</u>		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u>												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>DIABETES MELLITUS</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
									<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/13</u> 19 <u>87</u> to <u>8/6</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>8/6</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED <u>8/6/87</u>		
22d. SIGNATURE <u>Pierre-Jerome Frantz</u>			22e. DEGREE <u>MD</u>							ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS							23d. LOCATION CITY OR TOWN GBMC-6701 NORTH CHARLES ST. TOWSON 21204		
23a. BURIAL, CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN Timonium Balto. Md.			
Burial			8/10/87			Dulaney Valley Mem. Gardens			COUNTY STATE			
24. FUNERAL DIRECTOR NAME			ADDRESS							25a. DATE REC'D. BY REGISTRAR		
			J. E. Lowell Lemmon, 10 W. Padonia Rd.							25b. REGISTRAR'S SIGNATURE <u>Julia Dawson-Lemmon</u>		

062343 VUE II 05

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 1. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

Item 8, Film G631
FOR STATE per F.H. 9-24-87 dw REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3 3 6 4

REG. NO.

I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTIMATED	MONTH	DAY	YEAR	2b. HOUR
Charles Ervin Young						<input type="checkbox"/>	8-22	187		
SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
Male	Black	Jan. 15, 1961 26	26			<input type="checkbox"/>	8-22-	187		2:14A M
BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH				
South Carolina		USA				Baltimore City				
CITY OR TOWN OF DEATH		10. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore		1900 Block Booth Street			Postal Clerk			Gov.		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO	13e. STREET ADDRESS			
Maryland		PG		District Heights		<input type="checkbox"/>	6701 Alwood Street			
14. FATHER'S NAME FIRST		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST		ADDRESS			
Clarence Young					Rosa Hinton		139 Astor Circle, Columbia,			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Rosa Lee Young-mother - S.C.				
(If Yes, Give War or Dates)		249 25 1453								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Gunshot wounds</u> DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
					<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:10 AM 8-22-87			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) Subject shot					
22d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street			21f. LOCATION STREET 1900 Block Booth St., Baltimore City, MD CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE					TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)		Charles P. Kokes, M.D.			DATE SIGNED 8-22-87					
ADDRESS		111 Penn St., Balto., MD 21201								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		
Burial		Aug. 27 1987			St. James Baptist Church Cemetery			Horrell Hill, S.W.C.		
24. FUNERAL DIRECTOR NAME		John T. Stewart			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Stewart		Funeral Home-4001 Benning Road, N.E.			AUG 25 1987			Julia Davidson-Reader		

136381 E 8380

11 January 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

21

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR Item 5 Film G630 8-13-87
STATE per phone FH SB
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2356

1. DECEDÆD NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
CHARLES S. YOUNG						AUGUST	12,	1987		10:55 P.M.		
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
Male		Black		10-16-1914 10 16 1916		72		YRS				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		BALTIMORE CITY MD.				
Baltimore, Md		USA										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
BALTIMORE		MARYLAND GENERAL HOSPITAL										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		124 W. FRANKLIN 1801		
Md				Baltimore				ADDRESS		21215		
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME						Holland	
Elsworth				Young	Estelle							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. INFORMANT		17. ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NA		216-07-8317		Shirley Contee		3409 Piedmont Ave.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS												
DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF THE LUNG												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
DUE TO, OR AS A CONSEQUENCE OF (c) MYELOSUPPRESSION SECONDARY TO CHEMO THERAPY												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
19b. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from AUGUST 12, 19 87, to AUGUST 12, 19 87, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on AUGUST 12, 19 87, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) did <input type="checkbox"/> view the body after death.												
22b. SIGNATURE <i>Samir Shabshab, M.D.</i>		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		22d. DATE SIGNED 8/12/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		c/o MARYLAND GENERAL HOSPITAL								
Samir Shabshab, M.D.		22e. ADDRESS		c/o MARYLAND GENERAL HOSPITAL								
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 8/12/87		23c. NAME OF CEMETERY OR CREMATORIUM New Cathedral		23d. LOCATION CITY OR TOWN Balto		COUNTY		STATE Md.		
24. FUNERAL DIRECTOR NAME James A. Morton		ADDRESS 1701 Laurens St.		25a. DATE REC'D. BY REGISTRAR AUG 13 1987		25b. REGISTRAR'S SIGNATURE <i>Jordan Appling</i>						
DHMH - 16 60M 7/84 (VRA 15, 4)												

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-train permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, medical examiner's name must be listed on this certificate.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

233001

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
<u>Donald Ray Young Jr.</u>						<u>8</u>	<u>5</u>	<u>87</u>	<u>60</u>	<u>AM</u>		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
<u>M</u>		<u>W</u>		MONTH	DAY	<u>56</u>				IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			YRS. MONTHS DAYS HOURS MIN.			
<u>Baltimore</u>		<u>U.S.A.</u>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<u>Baltimore</u>						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
<u>Baltimore</u>		<u>SINAI HOSPITAL</u>				<u>Salesman</u>			<u>General Electric</u>			
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS ZIP CODE			MD. 21157			
<u>Maryland Carroll</u>		<u>Westminster</u>				<u>2334 Halter Rd.</u>						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES?			17. INFORMANT ADDRESS		
<u>Donald Ray</u>				<u>Young</u>	<u>Minnie Isaac</u>		<u>Yes Korean</u>			<u>Joan M. Young Same as #13</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<u>Cardiac Arrest</u>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO, OR AS A CONSEQUENCE OF <u>Cerebral Infarct</u>										
(c)		DUE TO, OR AS A CONSEQUENCE OF <u>Myocardial Infarction</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY			STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7-6</u> , 19 <u>57</u> , to <u>8-6</u> , 19 <u>57</u> , that (I) (we) last saw the deceased alive on <u>8-5</u> , 19 <u>57</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.												
22b. SIGNATURE		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22d. DATE SIGNED						
<u>Arthur H. Sleeper</u>						<u>8/15/87</u>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										
<u>Arthur H. Sleeper M.D.</u>		<u>Sinai Hospital</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		23e. DATE REC'D. BY REG. RAR			23f. REGISTRAR'S SIGNATURE	
<u>Cremation</u>		<u>8-6-57</u>		<u>Carroll Cremation</u>		<u>Hampstead Carroll Rd.</u>		<u>AUG 7 1987</u>			<u>Julie Dawson-Landress</u>	
24. FUNERAL DIRECTOR NAME		ADDRESS										
<u>Thomas J. Fletcher</u>		<u>Westminster</u>										

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN CIRCLE IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3 RETAINING ONE COPY FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 2, 2A, AND 2B SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2 3 3 6 7				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF DEATH ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR
JOHN			P.			YOUNG						<input checked="" type="checkbox"/>	8	10	1987	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR		
Male	White	DEC. 20, 1923			63 yrs.	MONTHS	DAYS	HOURS	MIN	8	10	1987	5:45 P.M.			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland			U.S.A.						Baltimore City							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION / TYPE OF WORK (FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore			Mercy Hospital (DOA)			Professor -Johns Hopkins Univ.										
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 8206 Thornton Rd. 21204							
14. FATHER'S NAME Paul			MIDDLE		LAST Young		15. MOTHER'S MAIDEN NAME First Sophia		Middle Lang							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO. Yes WW II 217-14-3038			17. INFORMANT Mary L. Young - same as #13e			ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?										
									YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												DATE SIGNED 8-11-87				
ACTUAL SIGNATURE						TITLE (SPECIFY) M.D. Deputy Chief MEDICAL EXAMINER										
EXAMINER'S NAME (TYPE OR PRINT)			Ann M. Dixon, M.D.			ADDRESS 111 Penn St., Balto., MD 21201										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 8-13-87			23c. NAME OF CEMETERY OR CREMATORIUM Mt. View Cemetery			23d. LOCATION CITY OR TOWN West Friendship, Howard, Md.							
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc., Towson, Md. 21204			ADDRESS 1050 York Rd.			25a. DATE REC'D. BY REGISTRAR AUG 13 1987			25b. REGISTRAR'S SIGNATURE Julia D. Darden							

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STATE
REGISTRAR

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23508

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
CAROL MAUDE YOWELL						8	2	87		0300 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IE UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
F		Cauc		MONTH	DAY	YEAR	54				
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
MARYLAND		U.S.				BALTIMORE CITY					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IE NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
BALTIMORE		SINAI HOSPITAL		SALES PERSON		RETAIL SALES					
13. USUAL RESIDENCE (IE NURSING HOME OR OTHER INSTITUTION GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13e. STREET ADDRESS / ZIP CODE					
MARYLAND		BALTIMORE		BALTIMORE		21234 9050 WALTHAM Woods Rd.					
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST		
SAMUEL Deceased		KENNETH		SNYDER	OLGA		M.		SORENSEN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IE YES, GIVE WAR OR DATES)						16b. SOCIAL SECURITY NO.					
UNKNOWN						219-30-3288					
17. INFORMANT						ADDRESS					
SANDRA C. YOWELL BALTIMORE, MD 21234											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LUNG CANCER</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY P.M. HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AI WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>7/15/87</u> , 19 <u>87</u> , to <u>8/2</u> , 19 <u>87</u> , that (1) (we) last saw the deceased alive on <u>8/2</u> , 19 <u>87</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.						22c. DATE SIGNED <u>8/2/87</u>					
22b. SIGNATURE <u>Roxanne S Donovan</u>						DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Roxanne S Donovan</u>						22e. ADDRESS <u>SINAI HOSPITAL</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
CREMATION		AUG. 4, '87		GREEN MOUNT CEMETERY		BALTIMORE, MARYLAND					
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR					
WILLIAM E. JOHNSON 8521 LOCH RAVEN BLVD.						25b. REGISTRAR'S SIGNATURE <u>Julia S. Johnson-Randall</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The doctor requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transcript permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 lists any injury, or other traumatic event, the medical Examiner will be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be paged or called.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												23369			
1. DECEASED NAME (TYPE OR PRINT)			FIRST			LAST			89 DATE OF DEATH MONTH DAY YEAR			REG. NO.			
Sophia V. Zaucha									8 24 87			10:45 AM			
3. SEX		4 RACE		5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		CAUCASIAN		MONTH 7 DAY 12 YEAR 12			75 YRS			MONTHS		DAYS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Pennsylvania		USA		9. BALTIMORE CITY OR COUNTY OF DEATH			Baltimore city MD								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		South Baltimore General										Tester		Westinghouse	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
MD		A.A.		Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			114 Doris Ave. 21225					
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST			LAST					
PAUL				DURAN			Eleanor			Ryba					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			ADDRESS					
No		269-12-5278		Eleanor Bentz			Cerebral Ischemia			20715					
18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.		(b) <u>previous CardioRespiratory</u>		(c) <u>Myocardial Ischemia</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>SEIZURES</u>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 8/13/87 to 8/24/87, that (I) (we) last saw the deceased alive on 8/24/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			South Baltimore General Hosp.			22f. DATE SIGNED							
VAZQUEZ								8/24/87							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN								
Burial		8/27/87		Glen Haven Mem Park			Glen Burnie			COUNTY		STATE			
A.A.										A.A.		Md			
24. FUNERAL DIRECTOR		George J. Goncze 4001 Ritchie Hwy Balto Md			25a. DATE OF REGISTRATION			25b. REGISTRATION SIGNAL							
					AUG 27 1987										

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper from pages 1 & 2. If page 2 is marked or shows any injury, or other traumatic event, the medical examiner must be notified at once.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 23370	
DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH DAY YEAR	26. HOUR
Paul	Franklin		Zechman	8-21-1987		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH 4 DAY 29 YEAR 1920	6. AGE (IN YEARS LAST BIRTHDAY) 67	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore	MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3634 Buena Vista 21211			12a. USUAL OCCUPATION Police Officer	12b. KIND OF BUSINESS OR INDUSTRY Police Depart.	
13a. STATE Maryland	13b. COUNTY Balto. City	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3634 Buena Vista 21211		
14. FATHER'S NAME FIRST: Frank MIDDLE: William LAST: Zechman	15. MOTHER'S MAIDEN NAME FIRST: Sarah MIDDLE: LAST: Zechman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. WW II 203-09-1198	17. INFORMANT Beulah A. Zechman 3634 Buena Vista 21211	ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Ventricular arrhythmia</i>						
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary artery disease</i>				SEVEN years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) <input type="checkbox"/> (the hospital) attended the deceased from May 9, 1986 , to August 19, 1987 , that (I) <input type="checkbox"/> saw the deceased alive on July 10, 1987 , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> (did not) view the body after death.						
22b. SIGNATURE <i>Dr. Frank J. Sutton</i>		22c. DEGREE 2nd	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED 8/24/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Frank J. Sutton		22e. ADDRESS Union Memorial Hospital				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/25/1987	23c. NAME OF CEMETERY OR CREMATORIAL Garrison Forest	23d. LOCATION CITY OR TOWN Garrison Forest	COUNTY Balto.	STATE Maryland
24. FUNERAL DIRECTOR NAME Burgee-Henss Funeral Home		ADDRESS 3631 Falls Road	25a. DATE REC'D. BY REGISTRAR AUG 25 1987	25b. REGISTRAR'S SIGNATURE <i>John H. Sutton</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 23371
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
John G. George ZELINSKY						August 9, 1987			11:40AM			
3. SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 10, 1914			6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter			12b. KIND OF BUSINESS OR INDUSTRY Genrl Mtrs Co.				
13a. STATE Maryland		13b. COUNTY -----		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6014 Walther Avenue 21206				
14. FATHER'S NAME FIRST George		MIDDLE -----		LAST Zelinsky		15. MOTHER'S MAIDEN NAME FIRST Catherine Wychkohsky		MIDDLE LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. -----			17. INFORMANT ADDRESS Marie Zelinsky 6014 Walther Avenue 21206		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 minute					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hypertension DUE TO, OR AS A CONSEQUENCE OF (c) hypertension												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Alzheimer disease												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Barbara A. Solomon, M.D.</i>		22c. DEGREE M.D.			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED Aug 10, 87					
22f. PHYSICIAN'S NAME (TYPE OR PRINT) Barbara A. Solomon, M.D.		22g. ADDRESS 8109 Harford Road Baltimore, Maryland										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug 13, 87		23c. NAME OF CEMETERY OR CREMATORIAL Holy Trinity Cemetery			23d. LOCATION CITY OR TOWN Elkridge		COUNTY STATE Maryland			
24. FUNERAL DIRECTOR NAME Dippel Funeral Home, Inc.		ADDRESS 7110 Belair Road Baltimore, Maryland 21206			25a. DATE REC'D. BY REGISTRAR AUG 11 1987		25b. REGISTRAR'S SIGNATURE <i>J. J. Dippel</i>					

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FOR
STATE
REGISTRAR
1787STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23372

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
ROSE					ZIELSKI	8	8	10	1987	3:00P.M.		
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
FEMALE		CAUCASIAN	MONTH	11	26	YEAR	12	YRS.	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				MD.	
MARYLAND		U.S.A.					CITY					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
BALTIMORE		SINAI HOSPITAL OF BALTIMORE			HOUSEWIFE			AT HOME				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		13f. ADDRESS				
MD		BALTO.	BALTO.	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3406 GARRISON FARMS, 21208		3406 GARRISON FARMS RD. BALTO., MD 21208				
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
WILLIAM		O'BECK		SARAH			UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT		ADDRESS					
NO		219-34-4261A			MELVIN ZIELSKI		3406 GARRISON FARMS RD. BALTO., MD 21208					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) IDIOPATHIC PULMONARY FIBROSIS												
DO TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/5/1987 to 8/10/1987, that (I) (we) last saw the deceased alive on 8/10/1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												
22b. SIGNATURE Thomas Rosenthal		22c. DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22d. DATE SIGNED 8/10/1987			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			SINAI HOSPITAL OF BALTIMORE							
THOMAS ROSENTHAL												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY	STATE		
BURIAL		AUG. 11, 1987		BALTIMORE HEBREW			REISTERSTOWN		BALTO.	MD		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215					25a. DATE REC'D. BY REGISTRAR AUG 14 1987							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The

TO FUNERAL DIRECTOR: After this certificate has been signed, it should be detached for use as the burial-transit permit and filed with the State Dept. of Health and Mental Hygiene.

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One prior to burial, cremation, or removal.

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completely filled in by the funeral director. page 1 and 2 should be filed within 72 hours after death.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23373

REG. NO.

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FOR
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1. DECEASED NAME (TYPE OR PRINT) BRITTANY Elaine ZILER			2a. DATE OF DEATH MONTH DAY YEAR 8-3-87	2b. HOUR 24 HRS 5:05 P.M.
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 7 31 87	6. AGE (IN YEARS LAST BIRTHDAY) 3 days yrs	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) M.D.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY MED CNT	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NA	12b. KIND OF BUSINESS OR INDUSTRY 9999 XNA. P.C. BOX 191 GREAT CAPA CON 25422	
13a. STATE MD			13b. COUNTY CITY	13c. CITY OR TOWN CITY
14. FATHER'S NAME Philip	FIRST H	MIDDLE ZILER	LAST	15. MOTHER'S MAIDEN NAME CHERYL
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) -	16b. SOCIAL SECURITY NO. -	17. INFORMANT Phillip & Cheryl Ziler, Great Cacapon, WV	ADDRESS 25422	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY IMMATURITY, HYALINE MEMBR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last - { DUE TO, OR AS A CONSEQUENCE OF (c) -				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) INTRACRANIAL HEMORRHAGE				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? NO	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? NO	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from 7-31-87 , 19 87 , to 8-3- , 19 87 , that (I) (we) last saw the deceased alive on 8-3- 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) leave the body after death.				
22b. SIGNATURE <i>R. Pathak</i>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 8-3-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AMBADAS PATHAK, M.D.	22e. ADDRESS 4940 EASTERN AVE. BALTIMORE, MD. 21224			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8/5/87	23c. NAME OF CEMETERY OR CREMATORIAL Great Cacapon Cemetery	23d. LOCATION CITY OR TOWN Great Cacapon, Morgan, WV	23e. COUNTY STATE Morgan, WV
24. FUNERAL DIRECTOR Helsley-Johnson F.H.	ADDRESS Berkeley Springs, WV	25a. DATE REC'D. BY REGISTRAR 8/5/87	25b. REGISTRAR'S SIGNATURE <i>H. H. Helsley-Johnson</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 9 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 18 is marked or item 19 shows any injury, or other trauma (not a medical event), the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
FOR STATE REGISTRAR			REG. NO. 23374								
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH			YEAR HOUR		
Gerard A. Zitnik						8-28-87					
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH 9 DAY 21 YEAR 20			6. AGE (IN YEARS LAST BIRTHDAY) 66		
									IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City		
10. CITY OR TOWN OF DEATH Balto.			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1651 Woodbourne Ave.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Elemente			12b. KIND OF BUSINESS OR INDUSTRY Retired-Environmental Corp.		
13a. STATE Md			13b. COUNTY Balt. City			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Anton Zitnik						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Kliment			13e. STREET ADDRESS / ZIP CODE 1651 Woodbourne Ave 21239		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW II			17. INFORMANT Rosalie M. Zitnik			ADDRESS 1651 Woodbourne Ave		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Coronary Artery Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Hypertension											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 6-22-87, to 8-28-87, that (I) (we) last saw the deceased alive on 6-22-87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Marion Kowalewski, M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8-28-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marion Kowalewski, M.D.			22e. ADDRESS 8604 Harford Rd.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-1-87			23c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer			23d. LOCATION CITY OR TOWN Baltimore City COUNTY Md.		
24. FUNERAL DIRECTOR NAME Ruck Towson			1050 York Rd.			25a. DATE REC'D. BY REGISTRAR AUG 31 1987			25b. REGISTRAR'S SIGNATURE Julia Stetson-Pendleton		
Funeral Home, Inc., Towson, Md. 21204											

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